CHILD REGISTRATION

CHILD INFORMATION

CHILD'S NAME Last _____ First _____ Middle Initial _____ Preferred Name: _____

Soc. Sec. # _____ SEX: _____ BIRTHDATE _____ AGE _____ FT Student: Y N If yes, Where: _____

Whom May We Thank for Referring You to our Office? _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

If Different from Above:

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE_____

EMAIL _____ May we Text you Appointment Reminders: _____ YES _____ NO

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT_____

EMPLOYER _____ Phone Number_____ .

CONTACT INFORMATION

PATIENT CELL PH_____ PARENT CELL._____ _____

May we text reminders Y N

PATIENT E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____

RELATIONSHIP_____

HOME PH. _____ CELL PH. _____

WORH PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co.Phone _____

Insured's Employer _____

Insured's Date of Birth _____

Insured's Soc. Sec. # _____ Group # _____ ID#_____

If you have secondary dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance cover with the above named insurance company and assign directly to Dr. Jason Daaboul all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This assignment and release will apply to any new insurance provided to the office in the future

Dr. Jason Daaboul may use my health care information and may disclose such information to the above-names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The Doctors also have my consent to use any photos taken without identifying information or full face, for use in journals, office use, website, and other advertising.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____