CHILD REGISTRATION

First Name:_____**Last Name:**_____

I like to be called:_____

Address:_____ **City:**_____ **Zip:**_____

Home phone #( )_____

Sex: Male ____ Female ____

Birth Date:_____ **Soc. Sec. #**_____

MOTHER'S INFORMATION (if applicable)

Name:_____

Cell phone # ( )_____

Birth Date:_____ **Soc. Sec.#**_____

Employer:_____ **Work phone#( )**_____ **Ext:**_____

Employer Address:_____ **City:**_____ **Zip:**_____

FATHER'S INFORMATION (if applicable)_

Name:_____

Cell phone # ( )_____

Birth Date:_____ **Soc. Sec.#**_____

Employer:_____ **Work phone#( )**_____ **Ext:**_____

Employer Address:_____ **City:**_____ **Zip:**_____

PRIMARY *DENTAL* INSURANCE INFORMATION (if applicable)

Name of Insured:_____ **D.O.B.:**_____ **ID #**_____

Insurance Company:_____ **Employer:** _____ **Group #**_____

SECONDARY *DENTAL* INSURANCE INFORMATION (if applicable)

Name of Insured:_____ **D.O.B.:**_____ **ID#**_____

Insurance Company:_____ **Employer:**_____ **Group #**_____

How did you hear about our office?_____

How would you rate your smile?

worst **0 1 2 3 4 5 6 7 8 9 10** best

Do you wish your teeth were straighter?

yes maybe no

Pharmacy Name and Phone #:_____