Welcome To Growing Smiles Pediatric Dentistry!

REGISTRATION FORM

TELL US ABOUT YOUR PATIENT

TODAY'S DATE

PATIENT'S FULL NAME (FIRST, LAST, PREFERRED NAME)

ADDRESS (STREET, CITY, STATE, ZIP)

PATIENT'S HOME PHONE

PATIENT'S SOCIAL SECURITY NUMBER

SEX ASSIGNED AT BIRTH
- ☐ MALE
- ☐ FEMALE
- ☐ OTHER

GENDER IDENTITY
- ☐ MALE
- ☐ FEMALE
- ☐ OTHER
- ☐ TRANSGENDER - MTF
- ☐ TRANSGENDER - FTM

DATE OF BIRTH (MM/DD/YYYY) AND CURRENT AGE

WHO IS ACCOMPANYING THE PATIENT TODAY?

NAME (FIRST, LAST)

RELATIONSHIP

DO YOU HAVE LEGAL PATIENT CUSTODY?
- ☐ YES
- ☐ NO

EMERGENCY CONTACT INFORMATION

NAME (FIRST, LAST)

RELATIONSHIP TO PATIENT

ADDRESS (STREET, CITY, STATE, ZIP)

HOME PHONE
- ☐ WORK
- ☐ CELL

PARENT/GUARDIAN INFORMATION

NAME OF PERSON RESPONSIBLE FOR PAYMENT

RELATIONSHIP TO PATIENT

PARENT/GUARDIAN #1 (FIRST, LAST, RELATIONSHIP TO PATIENT)

PARENT/GUARDIAN #1 RELATIONSHIP STATUS
- ☐ MARRIED
- ☐ DIVORCED
- ☐ SINGLE
- ☐ PARTNERED
- ☐ WIDOWED

HOME PHONE
- ☐ WORK
- ☐ CELL

ADDRESS (STREET, CITY, STATE, ZIP)

SOCIAL SECURITY #

DOB (MM/DD/YYYY)

PARENT/GUARDIAN #2 (FIRST, LAST, RELATIONSHIP TO PATIENT)

PARENT/GUARDIAN #2 RELATIONSHIP STATUS
- ☐ MARRIED
- ☐ DIVORCED
- ☐ SINGLE
- ☐ PARTNERED
- ☐ WIDOWED

HOME PHONE
- ☐ WORK
- ☐ CELL

ADDRESS (STREET, CITY, STATE, ZIP)

SOCIAL SECURITY #

DOB (MM/DD/YYYY)

EMAIL ADDRESS

WOULD YOU LIKE TO RECEIVE EMAIL REMINDERS?
- ☐ YES
- ☐ NO

TEXT REMINDERS?
- ☐ YES
- ☐ NO

PLEASE LIST ALL EMAIL ADDRESSES:

PRIMARY #

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REGISTRATION FORM

PATIENT'S NAME

PRIMARY INSURANCE INFORMATION

NAME OF INSURED (FIRST, MIDDLE, LAST)

HOME PHONE ☐ WORK ☐ CELL

DATE OF BIRTH (MM/DD/YYYY)

MEMBER ID# GROUP#

ADDRESS (STREET, CITY, STATE, ZIP)

SOCIAL SECURITY # DOB (MM/DD/YYYY)

INSURED'S EMPLOYER NAME

ADDRESS (STREET, CITY, STATE, ZIP)

INSURED'S PLAN NAME

PATIENT'S RELATIONSHIP TO PRIMARY INSURED

☐ SELF ☐ SPOUSE ☐ PATIENT ☐ OTHER

SECONDARY INSURANCE INFORMATION

NAME OF INSURED (FIRST, MIDDLE, LAST)

HOME PHONE ☐ WORK ☐ CELL

DATE OF BIRTH (MM/DD/YYYY)

MEMBER ID# GROUP#

ADDRESS (STREET, CITY, STATE, ZIP)

SOCIAL SECURITY # DOB (MM/DD/YYYY)

INSURED'S EMPLOYER NAME

ADDRESS (STREET, CITY, STATE, ZIP)

INSURED'S PLAN NAME

PATIENT'S RELATIONSHIP TO PRIMARY INSURED

☐ SELF ☐ SPOUSE ☐ PATIENT ☐ OTHER

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