Chart#___________________
(office use only)

CORONA KIDS DENTAL REGISTRATION FORM

Thank you for taking a moment to enter or update your information.
Please answer every question as detailed and as accurately as possible.

Patient Information

Patient Name: ____________, ____________ ____
Last First MI

Preferred Name: ____________

Gender: ☐Male ☐Female

Birth Date: ____ / ____ / ______ (mm/dd/yyyy)

Email Address: ____________ @ ____________
(Email for office communication only, no spam.)

Best phone to reach you: ☐Home ☐Work ☐Mobile

Home Phone: (____) ____ - ______

Work Phone: (____) ____ - ______

Mobile Phone: (____) ____ - ______

Address: ____________________
____________ ____ ______
City State Zip

Responsible Party Information

Information of 2nd parent other than the insurance subscriber.

Relationship to patient: ☐Mom ☐Dad ☐Legal Guardian

Name: ____________, ____________ ____
Last First MI

Gender: ☐Male ☐Female

Family Status: ☐Married ☐Single ☐Divorced

Birth Date: ____ / ____ / ______ (mm/dd/yyyy)

Social Security # ____ - ____ - ______

Driver License # ____________

Phone Numbers: ☐Same as patient ☐Diff. (enter below)

Best phone to reach you: ☐Home ☐Work ☐Mobile

Home Phone: (____) ____ - ______

Work Phone: (____) ____ - ______

Mobile Phone: (____) ____ - ______

Address: ☐Same as patient ☐Different (enter below)
____
____________ ____ ______
City State Zip

Dental Insurance Information

Information of the insurance subscriber

Relationship to patient: ☐Mom ☐Dad ☐Legal Guardian

Name of Insured: ____________, ____________ ____
Last First MI

Insured's Birth Date: ____ / ____ / ______ (mm/dd/yyyy)

Insured's Social Security #: ____ - ____ - ______

Member ID#: ____________ (if different from SS#)

Insured's Driver License # ____________

Insurance Group#: ____________

Insured's Employer Name: ____________

Insurance Plan Name: ____________

Insurance Co. Phone: (____) ____ - ______

Insurance Co. Address: ____________________
____________ ____ ______
City State Zip

Phone Numbers: ☐Same as patient ☐Diff. (enter below)

Best phone to reach you: ☐Home ☐Work ☐Mobile

Home Phone: (____) ____ - ______

Work Phone: (____) ____ - ______

Mobile Phone: (____) ____ - ______

Insured's Address: ☐Same as patient ☐Diff. (enter below)
____
____________ ____ ______
City State Zip

Whom may we thank for referring you to our practice?

☐ Other Dental Office ☐ Pediatrician
☐ Direct-Mail Postcard ☐ Phone Book
☐ Our Website ☐ Internet (other)
☐ Insurance Company ☐ Work
☐ School ☐ Other (name below)

Please write the name of person, or entity that referred you :
____

Confirmation of Accuracy

Please check here ☐ and sign below to confirm that: “I am the parent or legal guardian (responsible party), and I confirm that all the preceding information (including but not limited to patient, insurance, parent/responsible party information, etc.) is true and correct. If there is ever a change in the preceding information, I will inform the office at my child’s next dental appointment without fail.”

Signature of parent, or legal guardian (Responsible Party):

____________________ X____________________ ____ / ____ / ______
Print Name Signature Date