Entered by___________
(office use only)

CORONA KIDS DENTAL REGISTRATION FORM

Thank you for taking a moment to enter or update you and your child's 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 required. For office communications only, no spam.)

Best mobile phone to reach you: ☐Mom ☐Dad ☐ ________
(____) ____ - ______ (Required for Appt reminders)

2nd mobile phone to reach you: ☐Mom ☐Dad ☐ ________
(____) ____ - ______ (Recommended)

Other Phone: ☐Home ☐Office ☐ ________
(____) ____ - ______

Address: ________________
________ ____ ______
City State Zip

Responsible Party Information

Parent/guardian who brought the patient to this appointment

Name: ________, ________ ____
Last First MI

Relationship to patient: ☐Mom ☐Dad ☐Legal Guardian

Family Status: ☐Married ☐Single ☐Separated/divorced

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

Social Security #: ____ - ____ - ______

Driver License #: ________

Address: ☐Same as patient (If diff. please enter below)
____
________ ____ ______
City State Zip

Dental Insurance Information

Please confirm that this child have: ☐**One** dental insurance
☐**Two** dental insurances

Please enter your **primary** dental insurance information below, and please give the **secondary** insurance information to our staff:

Name of Insured: ________, ________ ____
Last First MI

Relationship to patient: ☐Mom ☐Dad ☐Legal Guardian

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

Insured Social Security #: ____ - ____ - ______

Member ID# (if diff. from SS#): ________

Insured Driver License #: ________

Insurance Group#: ________

Insured Employer Name: ________

Insurance Plan Name: ________

Insurance Co. Phone: (____) ____ - ______

Insured Address: ☐Same as patient (If diff. please enter below)
____
________ ____ ______
City State Zip

Whom may we thank for referring you to our practice?

☐ Caring Friends/Family	☐ Pediatrician
☐ Our Website	☐ Phone Book
☐ School	☐ Internet
☐ Insurance Company	☐ Work
☐ Direct-Mail Postcard	☐ Other Dental Office

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

Confirmation of Accuracy

Please sign below to confirm that: "I am the parent or legal guardian (responsible party), and I confirm that all the preceding information in this form is true and correct. I further confirm that our insurance coverage is active and current. If there is ever a change in the preceding information, I will inform the office immediately and before dental service is provided without fail."

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

________________ X________________________ ____ / ____ / ______
Print Name Signature Date