Cottonwood DENTAL CARE, PA

Child Patient Registration

Patient Information:

Patient Name: _____ Sex: _____ Birth Date: _____
Patient's Social Security Number: _____ School: _____

Parents/Guardian Information:

Mother's name: _____ Birth Date: _____
Marital History
___Single ___Married ___Widowed ___Separated ___Divorced
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Father's name: _____ Birth Date: _____
Marital History
___Single ___Married ___Widowed ___Separated ___Divorced
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

In case of emergency, notify: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you? _____ Relationship: _____

Employment History (Parents/Guardian):

Father/Guardian employed by: _____ Phone: _____
Business address: _____
Present position: _____ How long held: _____

Mother/Guardian employed by: _____ Phone: _____
Business Address: _____
Present Position: _____ How long Held: _____

Financial Information (Parents/Guardian):

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature_____ Date_____
Person/s responsible for this account: _____

Mother's Social Security Number: _____ Drivers license number: _____

Father's Social Security Number: _____ Drivers license number: _____

If using Credit/Debit Card to pay for services: Name: _____ Card # and exp. Date: _____
If on **Medicaid**, your number: _____ County: _____

If patient has primary insurance, name & address of insurance company: _____
_____ Subscriber Name & ID#: _____
Group#_____

If patient has secondary insurance, name & address of insurance company: _____
_____ Subscriber Name & ID#: _____
Group#_____