Welcome to Power Road Dental Care

Child Registration

Patient_____
First Middle Last
Sex: M___F___ Birthdate_____ Age_____ Social Security #_____

Mother's name_____ Father's name_____
Address_____ Address_____
_____ _____
Home Ph #_____ Home Ph #_____
Cell Ph #_____ Cell Ph #_____
Employer_____ Employer_____
Work Ph #_____ Work Ph #_____

Who does this child live with?_____
What is the purpose of this appointment?_____
When and where was the child's last dental visit?_____
Names of brother's and sisters_____

Primary Dental Insurance Information

Subscriber's name_____
Subscriber's address_____
Subscriber's SS#_____ Birthdate_____
Relationship to patient_____
Subscriber's employer_____
Business address and phone_____
Insurance Company_____ Phone #_____
ID#_____ Group #_____

Secondary Dental Insurance Information

Subscriber's name_____
Subscriber's address_____
Subscriber's SS#_____ Birthdate_____
Relationship to patient_____
Subscriber's employer_____
Business address and phone_____
Insurance Company_____ Phone #_____
ID#_____ Group #_____

In case of an emergency who should be notified? Please give name and phone number.

Relative_____
Non-Relative_____