

# Welcome to Power Road Dental Care

## Child Registration

Patient \_\_\_\_\_

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 \_\_\_\_\_

