



SMILES BRIGHTER THAN THE NORTHERN LIGHTS

Registration & Health History Form

Today's Date: ____/____/____

Welcome! To our dental office, where we provide individualized care for infants, toddlers, children and teens! Our focus is on prevention and early management of dental disease. We are honored that you have entrusted your child's care to us. We take great pride in providing a comfortable experience for children and their families. Should you have any special request, please inform us and we will do our best to accommodate you.

How did you hear about us? Google Facebook Twitter Internet Newspaper Insurance Search
 Other: _____

Tell us about your child:

Name: _____
 Goes by: _____ Male Female
 Birth date: ____/____/____ Age: _____
 School: _____ Grade: _____
 Home address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: (____) _____

Parent one: Mom Dad Guardian

Name: _____
 DOB: ____/____/____
 Best way to contact: (____) _____ H W C
 Email: _____
 SS#: ____/____/____

Dental Insurance: Primary

Insurance company name: _____
 Policy owner's name: _____
 Policy owner's birth date: _____
 SSN#: ____/____/____
 Member number: _____
 Group number: _____
 Relationship to patient: _____
 Address: _____
 Insurance number: (____) _____

Who is accompanying your child today?

Name: _____
 Relationship: _____

Do you have legal custody of your child? Yes No

Is there anyone you would like to designate to bring your child for dental appointments other than mom/dad? If yes, please list:

Name & relationship: _____
 Name & Relationship: _____

Parent two: Mom Dad Guardian

Name: _____
 DOB: ____/____/____
 Best way to contact: (____) _____ H W C
 Email: _____
 SS#: ____/____/____

Dental Insurance: Secondary

Insurance company name: _____
 Policy owner's name: _____
 Policy owner's birth date: _____
 SSN#: ____/____/____
 Member number: _____
 Group number: _____
 Relationship to patient: _____
 Address: _____
 Insurance number: (____) _____

