

Laurelwood Dental

Child Registration

About Your Child

Today's Date: _____ E-mail Address: _____

Child's Name: _____ They prefer to be called: _____ male _____ female
Last First MI

Child's Birthdate: ____/____/____ Age: _____

Home Address: _____
Street City State Zip

Child lives with: Mother Father Other: _____

Whom may we thank for referring you? _____ OR _____
Friend / Relative / Doctor Internet Site

Responsible Party Information

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext.: _____

Home Phone #: _____ Cell #: _____ When are the best times to reach you?: _____

Mother / Step Mother / Guardian Information

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext.: _____

Home Phone #: _____ Cell #: _____ When are the best times to reach you?: _____

Father / Step Father / Guardian Information

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext.: _____

Home Phone #: _____ Cell #: _____ When are the best times to reach you?: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone #: _____ Group / Plan #: _____

ID #: _____ Insured's Employer: _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's SS #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Secondary Insurance Company: _____ Phone #: _____ Group / Plan #: _____

ID #: _____ Insured's Employer: _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's SS #: _____ Insured's Birthdate: ____/____/____ Relation: _____