PEDIATRIC PATIENT REGISTRATION

Complete the appropriate forms online and send them to us prior to your visit at Best Smiles. This will help us make your visit as pleasant and efficient as possible.

Patient Information

Name *

First | Middle | Last

Nickname

Address *

Street Address

City | State / Province / Region

ZIP / Postal Code

Gender *

- ◯ Female
- ◯ Male

Race *

Ethnicity *

Birthday *

Place of Birth

Names and Ages of Siblings

Favorite Sport

Favorite Hobby

Favorite Toy

Favorite Person

Favorite Fictional Character

Favorite TV Personality

Does your child have a pet?

What kind of pet?

Pets name

Mother's Information

Mother's Name *

First | Middle | Last

Preferred Name

Preferred Title *

- ○ Mrs.
- ○ Ms.
- ○ Dr.
- ○ Attorney
- ○ Other
- ○ Other

Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

Home Phone

Cell Phone *

Work Phone

Ext.

Email *

Birthday *

Social Security Number *

Driver's License Number *

State *

Alabama

Marital Status *

Single

Employer *

Occupation *

Business Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

Father's Information

Father's Name *

First

Middle

Last

Preferred Name

Preferred Title *

- ○ Mr.
- ○ Dr.
- ○ Attorney
- ○ Other
- ○ Other

Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

Cell Phone *

Home Phone

Work Phone

Ext.

Email *

Birthday *

Social Security Number *

Driver's License Number *

State *

Alabama

Marital Status *

Single

Employer *

Occupation *

Business Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

Financially Responsible Party

Name *

First

Middle

Last

Relationship to Patient *

Address

Street Address

Address Line 2

City

State / Province / Region

ZIP / Postal Code

Country

Preferred Title *

- ◯ Miss
- ◯ Ms.

- ◯ Mrs.
- ◯ Mr.
- ◯ Dr.
- ◯ Attorney
- ◯ Other
- ◯ Other

Cell Phone *

Home Phone

Work Phone

Ext.

Email *

Birthday *

Social Security Number *

Driver's License Number *

State *

Alabama

Marital Status *

Single

Employer *

Occupation *

Business Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

Insurance Information

Policy Holder's Name *

First

Last

Social Security Number *

Insurance Company *

Group # *

Identification # *

Insurance Company Address *

Street Address

Address Line 2

City

State / Province / Region

ZIP / Postal Code

Insurance Company Address *

Street Address

Address Line 2

City

State / Province / Region

ZIP / Postal Code

Insurance Phone *

Policy Holder's Employer *

Do you have dual coverage? *

- ◯ No
- ◯ Yes

Secondary Insurance Information

Policy Holder's Name

First

Last

Social Security Number

Insurance Company

Group #

Identification #

Emergency Information

Name of nearest relative not living with your child *

First

Last

Relationship *

Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

Cell Phone *

Home Phone

Work Phone

Ext.

Email *

Parent's Confidential Commination

How do you prefer to be contacted? Check all that apply. *

- [ ] Home Phone
- [ ] Cell
- [ ] Work
- [ ] Email
- [ ] Text

Where can we leave voicemail / answering machine messages? *

- [ ] Home Phone
- [ ] Cell
- [ ] Work

With whom can we discuss your child's health with?

First

Last

Relationship

With whom can we discuss your child's health with? (con't)

First

Last

Relationship

How and When Did You Become Aware of Our Office?

Whom can we thank for referring you to us?

First

Last

How and when did you first hear about us?

- Family Member
- Friend
- Co-Worker
- Internet
- Facebook
- TV
- Walk / Drive-by
- Physician
- Dentist

- ◯ Radio
- ◯ Newspaper
- ◯ Direct Mail

Consent for Services - Please Print and Sign Below

AUTHORIZATION AND REALEASE: I hereby authorize payment directly to the doctor for any dental benefits otherwise payable to me. I understand I am financially responsible for all charges not covered by this assignment. I authorize this office to release any dental and medical information required to investigate or evaluate any claims for benefits to insurance companies, health care service plans, self-insurers, or their representatives. If an insurance check is made directly to me, I am responsible for immediately sending said check to this office.

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT: I understand and acknowledge that it is ultimately my responsibility to pay for all dental services rendered to me and/or my dependents including reasonable attorney's fees and costs of collection in the event of default. I understand that if at any time my insurance plan does not cover my services I agree to pay all charges. I agree that I am responsible for any unpaid balance on my account and that a service charge of 1.5% per month (18% per annum) OR $2.50 per month, which ever is greater, will be charged on the unpaid balance of all accounts exceeding 30 days, unless previously financial arrangements in writing are made.

I understand that when any check or e-check issued in payment for any fee is returned as uncollectible or a payment of any fee by means of a credit or debit card is rejected or dishonored, this office will charge a $35.00 fee.

I understand that failing, canceling, and/or rescheduling an appointment with less than a 24-business-hour notice will be subject to a minimum charge of $40 per half hour of the reserved time.

ACCURACY AND ACKNOWLEDGMENT: The information give by me on this form is accurate and true to the best of my knowledge. I have read the above conditions of treatment and payment and agree to the content. I grant my permission to this office or assignee, to contact me by telephone (home, work, cell) or email to discuss matters related to this form.

Signature and Date

Printed Name

First

Last

Relationship to the Patient

SUBMIT