Minor Patient Registration Form

Provider: RJA DCD BJG RJL JEM DDS KJG KAS

PLEASE PRINT CLEARLY

Referring Doctor: ____
First and Last Name | City, State | Phone #

Child's Name: ____
Last | First | Middle Initial

Date of Birth: ____/____/____ Sex: __ Male __ Female Prefer to be called: ____________

Home Address: ____
Street # | Street Name | Apt. #

____
City | State | Zip

Legal Guardian/Parent Name:____
Last | First | Initial

Guardian Social Security # ________________________ Guardian Date of Birth: ___/___/___

□Home Phone (____) ______________ □Work (____) ______________ □Cell (___) ______________

(Please check the box next to the phone number where you would like to receive appointment reminder calls)

Guardian E-Mail address: ____

May we mail or e-mail you special offers? Yes_____ No_____

INSURANCE COVERAGE – PRIMARY

Insurance Co. Name: ____

Name of Policy Holder (Insured): ______________________________

Policy Holder Social Security #: ______________________________

Policy Holder Date of Birth: ____/____/____

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name: ____

Name of Policy Holder (Insured): ______________________________

Policy Holder Social Security #: ______________________________

Policy Holder Date of Birth: ____/____/____

FINANCIAL POLICY:

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductibles, co-payments, and non-covered services.)

______________________________ _____/_____/_____
Signature of parent or legal guardian Date

I have received a Notice of Privacy Practices from D.A.W.M. **Initial ________ Date: _____/_____/___**

How did you hear about us: Radio___Advance___GRPress___InternetWebsite___Family/Friend___Other___

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your answering machine at home? ____ Yes ____ No

Discuss your child's medical condition with any member of your household? ____ Yes ____ No

If yes, whom: 1) ______________________________ Relationship: ______________

2) ______________________________ Relationship: ______________

______________________________ _____/_____/_____
Signature of Parent/Legal Guardian Date

Please present insurance card(s) and photo ID to the receptionist so copies may be made.