YOUTH REGISTRATION FORM

Youth's Name: _____
Last First Nickname Birthdate

Residence Address _____
Number Street City State Zip Code Telephone

Name of School _____ Grade _____

Person Responsible for Account:

Name _____
Last First Middle

Residence Address _____
Number Street City State Zip Code Telephone

Business Address _____
Number Street City State Zip Code Telephone

Occupation _____ Employer _____

By whom were you referred? _____

I, the undersigned, authorize dental treatment to be rendered by the Dentist and his staff, and assume financial responsibility.

Signature _____ Date _____

CHILD'S HEALTH HISTORY:

Physicians name: _____
Address: _____
Frequency of medicines during formation of permanent teeth? _____
History of serious illness: _____
Mother's health during pregnancy? _____ History of Rheumatic fever? _____
Frequency of medicines during first 2 years of life? _____
Any drug staining of teeth? _____ Any medications taken regularly? _____
Any drug allergies? _____
Any medical problems? _____

INSURANCE INFORMATION

If you have any type of dental insurance, please complete the following.

Name of Insurance Carrier _____ Group number _____

Employee _____ Employee's Social Security Number _____
Birthdate

Patient _____ Relationship to Employee _____ Patient's Birthdate _____

Employer _____
Address Area Code Telephone

Union Local Number _____
Address

Has the patient had previous dental care under this plan? _____

Is the patient covered by another plan? _____ If so, name of plan _____

Employer _____
Address Area Code Telephone