Ravenna Family Dentistry
CHILD/MINOR REGISTRATION
(Confidential)

Date: ______________

PATIENT INFORMATION

Name of Minor Child: Last__________________________First________________________MI_____
Sex ___M ___F Age________ Birthdate___________ Nickname (if any)_______________________
Home Address ____
Person Financially responsible ____________________________________ Relationship to child_____________
Billing Address____
Home phone ______________ Work phone_____________________ Cell_______________________
Email address____

Whom may we thank for referring you to us? ____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name: Last____________________________First_______________________________MI_________
Relationship to patient______________________________Birthdate_______________Soc Sec #_________________
Address (if different from child) ____
Subscriber Employed By____ Occupation_________________________
Subscriber Address____Business Phone_________________
Dental Insurance Company____
Contract #_____________________ Group #__________________________ Subscriber #________________________

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name: Last____________________________First_______________________________MI_________
Relationship to patient______________________________Birthdate_______________Soc Sec #_________________
Address (if different from child) ____
Subscriber Employed By____ Occupation_________________________
Subscriber Address____Business Phone_________________
Dental Insurance Company____
Contract #_____________________ Group #__________________________ Subscriber #________________________

EMERGENCY CONTACTS

In the event of an emergency, whom should we contact?
Name____________________________________ Relationship______________________ Phone__________________
Name____________________________________ Relationship______________________ Phone__________________

Please list any other persons with whom we may discuss/disclose your child's dental treatment and/or communicate information protected by HIPAA, if any:
Name(s) and relationship(s) to child____
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