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Dino Kid's DENTISTRY
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# PATIENT REGISTRATION

| | | | |
|---|---|---|---|
| PATIENT NAME (Last, First, Middle Initial) | | | DATE OF BIRTH |
| ADDRESS | | | SOCIAL SECURITY NUMBER |
| CITY, STATE, ZIP | | | WHO CAN CONSENT? ☐ Mom ☐ Dad or ☐ Other |
| HOME PHONE | WORK PHONE | CELL PHONE | EMAIL ADDRESS |
| PREFER ☐ Morning Appointment ☐ Afternoon Appointment | | | RELATIONSHIP TO INSURED ☐ Self ☐ Spouse or ☐ Child |
| SCHOOL NAME | | | Sex ☐ Male or ☐ Female |

## OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE

| | | |
|---|---|---|
| NAME: | DOB: | SSN: |
| NAME: | DOB: | SSN: |

## WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

| | |
|---|---|
| NAME: | PHONE: |

## REFERRED TO THIS OFFICE BY:

| | |
|---|---|
| NAME: | PHONE: |

## INSURANCE INFORMATION

| PRIMARY COVERAGE | SECONDARY COVERAGE |
|---|---|
| SUBSCRIBER'S NAME | SUBSCRIBER'S NAME |
| DATE OF BIRTH | DATE OF BIRTH |
| INSURANCE COMPANY | INSURANCE COMPANY |
| GROUP NUMBER | GROUP NUMBER |
| LOCAL NUMBER OR POLICY NUMBER | LOCAL NUMBER OR POLICY NUMBER |
| EMPLOYER | EMPLOYER |
| OCCUPATION | OCCUPATION |

| | | |
|---|---|---|
| UPDATED ON | SIGNATURE | DATE |

## OFFICE USE ONLY VERIFICATION BENEFIT

Effective date: _____

Yearly Plain Maximum $:_____ Calendar Year: _____

Ind Ded. $: _____ Fam Ded. $_____ W/Prev: Y or N Met: Y or N

Class1 _____% Class2_____% Class3_____%

Perio: _____ Endo: _____Ext: _____ Implants:_____

Prosthetic Replacement: _____ Alternate Benefit: _____

FMX/Pano: _____ BWX: _____Exam: _____Prophy:_____

Sealants:_____ Fluoride: _____ Nightguard: _____Denture:_____

Quad Scaling: _____ Perio Maint: _____ Atridox(4381): _____

Waiting Period for Major:_____

Missing Tooth Clause:_____

Ortho Maximum $:_____ Used$:_____ Age limit:_____

USED TO DATE $_____ DATE VERIFIED_____

## Comment

_____

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