OAK VALLEY DENTAL ASSOCIATES

CHILD REGISTRATION FORM

Name: ______________________________ Birthdate: ___/____/___

Preferred To Be Addressed As: ____________________ Male □ Female □

Address: ____________________ City: ______________ State: _____ Zip: __________

Home Phone: (___) __________ Cell Phone: (____) ______________

Parent(s) Names: ____________________________ E-mail Address: ______________

Person Responsible for Account: Mother □ Father □ Other, explain: ___________

Name: ____________________ Birthdate: ___/____/___ SS#: __________________

Address (if different than above): ____________________________________

City: ____________ State: _______ Zip: __________ Phone: (___) ______________

Employer: ______________________ Employer's Address: ______________________

Work Phone: (____) ______________ City: ____________ State: _______ Zip: _______

Whom May We Thank For Referring You? ____________________________________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name: ____________________________ Group No: _____________

Insurance Company Address: __________________________ Phone No: _____________

City: ______________ State: _______ Zip: ________

Insured's Name: _________________ SS or ID No: _____________ Birthdate: ___/____/___

Insured's Employer: ______________

Secondary Dental Insurance

Insurance Company Name: ____________________________ Group No: _____________

Insurance Company Address: __________________________ Phone No: _____________

City: ______________ State: _______ Zip: ________

Insured's Name: _________________ SS or ID No: _____________ Birthdate: ___/____/___

Insured's Employer: ______________

Does Your Child Have Any Special Interests (e.g. Sports, Hobbies, Toys, etc.)?______________

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School child attends: ____

Other information the doctor may need to know about your child: ______________________

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AUTHORIZATION AND RELEASE

Your payment/insurance co-payment is due at the time service is rendered. We accept cash, check and credit cards.

I authorize Oak Valley Dental Associates to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Oak Valley Dental Associates insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X______________________________________ Date: ____________________________

Signature of patient (or parent if minor)

Please complete other side of form