Kids Dentist Patient Registration Form

1. Please enter patient/child's information:

First Name:	Last Name:	Preferred Name/Nickname
Gender	Date of Birth:	Street Address:

Apt./Unit #: City: State: Zip Code:

Mobile Phone: Email:

Parent/Guardian 1 Information

2. Family Role

Relationship To Patient

3. Parent/Guardian 1

First Name: Last Name: Date of Birth:

Street Address: Apt./Unit #: City:

State: Zip Code: Mobile Phone: Email:

Preferred Method of Communication
☐ Call ☐ Text ☐ Email

Best time to Call
☐ AM ☐ PM

Employer Name Job Title

4. Please add government issued ID, Drivers' license, or passport

PDF or Jpeg files must be uploaded.

Parent/Guardian 2 Information

5. Is there an additional parent/guardian for this account? If you answered YES to the question below, you must continue to answer the next section.

○ Yes (Please fill out the pertinen information of the person.)

○ No

6. Family Role

Relationship To Patient

7. Name of Parent/Guardian 2

First Name: Last Name: Date of Birth:

Street Address: Apt./Unit #: City:

State: Zip Code: Mobile Phone: Email:

Employer Job title

Preferred Method of Communication
☐ Text ☐ Email ☐ Call

Best time
○ AM ○ PM

8. **Please add second parent/guardian's government issued ID, Drivers' license, or passport**

PDF or Jpeg files must be uploaded.

Insurance Information

As a courtesy, Kids Dentist can submit insurance claims on your behalf. Insurance is a contact between you and your insurance company. You must fill out a separate insurance form completely in order for us to submit on your behalf.

9. **Please select one of the following options:**

○ We have dental insurance and would like Kids Dentist to submit to our insurance

○ We do NOT have dental insurance

Dental Insurance Information

10. **Which type of dental insurance, do you have?**

○ One Dental Insurance ○ Dual Dental Insurance

11. **In order to submit to a dual or secondary insurance, both companies need to be aware your child is double insured.**

Are both of your insurance companies aware that you have 2 insurances?
☐ Yes ☐ No ☐ Don't know (I will confirm with my insurance companies)

12. Is your primary insurance determined by the birthdate rule?

☐ Yes ☐ No ☐ Do not know

If not, Explain:

_____

13. Please enter your Primary Subscriber information.

Subscriber's First Name: _____ Subscriber's Last Name: _____ Subscriber's Date of Birth: _____

Subscriber's Street Address: _____ Apt./Unit #: _____ City: _____

State: _____ Zip Code: _____ Mobile Phone: _____ Email: _____

Primary Dental Insurance Company _____ Relationship to Patient _____

Primary Insurance ID # _____ Insurance Group Number _____

Subscriber's Employer _____

14. Upload Primary Insurance Card

Secondary Dental Insurance

If you have Secondary Insurance, please continue to fill out the following questions. If not, continue to next section.

15. Please enter your Secondary Subscriber information.

Subscriber's First Name: _____ Subscriber's Last Name: _____ Subscriber's Date of Birth: _____

Subscriber's Street Address: _____ Apt./Unit #: _____ City: _____

State: _____ Zip Code: _____ Mobile Phone: _____ Email: _____

Secondary Dental Insurance Company _____ Relationship to Patient _____

Secondary Insurance ID # _____ Insurance Group Number _____

Subscriber's Employer

16. Upload Secondary Insurance Card

Consent to treatment

By providing my electronic signature below I, the unsigned (patient or legally responsible party), authorize dental treatment to be rendered by the dentists and staff of Kids Dentist and will keep them informed if changes occur in my child's health or our other information.

If the patient is a minor, I affirm that i have the legal authority to consent on this child's behalf.

17. In an emergency who should be notified? Please provide name and phone number below

Emergency Contact Name

Emergency Contact Relationship to Child

Emergency Contact Phone Number

Authorization

By providing my electronic signature below, I, the undersigned (patient or legally responsible party), hereby consent to treatment as recommended by my provider. This consent shall be considered in effect until rescinded or revoked. I will keep them informed if changes occur in my child's health or our other information. I authorize Kids Dentist to submit insurance claims on my behalf, if applicable, and assume financial responsibility for all fees, as the insurance plan is contact between myself and my insurance carrier (not the dentist and the Ins Co). It is your responsibility to inform our office of any changes to insurance.

Signature

Date

18. Type name signature

Name of signature

Relationship to patient

Date