

ACCOUNT INFORMATION
FAMILY REGISTRATION FORM

PATIENT(S)

Child #1: Name _____

(Circle) Male or Female Date of Birth _____

Child #2: Name _____

(Circle) Male or Female Date of Birth _____

Child #3: Name _____

(Circle) Male or Female Date of Birth _____

Child #4: Name _____

(Circle) Male or Female Date of Birth _____

For more than 4, please request additional form.

MOTHER OR Stepmother Guardian

Name _____ Home Ph _____

Work Ph _____ Ext _____ Cell Ph _____

Address, if different from patient(s) _____

City, State, Zip _____

DOB: _____ SS# _____ DL# _____

Employer: _____ Occupation: _____

Marital Status (Circle) Single Married Divorced Widowed Separated

FATHER OR Stepfather Guardian

Name _____ Home Ph _____

Work Ph _____ Ext _____ Cell Ph _____

Address, if different from patient(s) _____

City, State, Zip _____

DOB: _____ SS# _____ DL# _____

Employer: _____ Occupation: _____

Marital Status (Circle) Single Married Divorced Widowed Separated

Contact E-mail: _____

Family Dentist _____ Physician _____

DENTAL INSURANCE

Policy Holder's Name _____ SS# _____

Birthdate _____ Relationship to Patient(s) _____

Insurance Co _____ Ins. Co. Phone _____

Employer _____ Occupation _____

Member ID# _____ Group # _____

Ins. Co. Address, City, State, Zip _____

Max. Annual Benefits _____ Deductible _____ Copay _____

Do You Have Secondary Dental Insurance: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name _____ Relationship to Patient(s) _____

Home Ph: _____ Cell _____ Work _____

Best Time to Call _____ Days _____

EMERGENCY INFORMATION, if other than parent/guardian

Who can we contact in case of emergency? _____

Relationship to Patient(s) _____ Home Ph _____

Cell Ph _____ Work Ph _____

Address _____

REFERRAL INFORMATION

How did you learn about our office? (Circle, if applicable) School Visit Yellow Pages

Sign Other (please list) _____

CONSENT

It is necessary that signed permission be obtained from the parent or guardian before any necessary dental services can be performed by staff of Dr. Michael Blen, DDS. Authorization is hereby granted as such. Furthermore, I agree to be financially responsible for payment of patient(s)' account.

Signed _____ Date _____

Relationship _____