Johnsonlink ORTHODONTICS

CHILD PATIENT REGISTRATION

CHILD'S INFORMATION

Today's Date _____

Legal Name Last _____ First _____ Middle _____

Preferred Name (If different) _____ Birthdate _____ Age _____

Gender _____ Child's Dentist _____

Who is accompanying the patient today? _____ Relationship _____

Other family members who are patients with us _____

Whom may we thank for referring you?

☐ Dentist or Doctor ☐ Patient of Our Office ☐ Other Name of Referrer _____

RESPONSIBLE PARTY

☐ Legal Guardian ☐ Financially Responsible

Name _____ Relationship to Patient _____

Phone Number [H] _____ [W] _____ [C] _____

E-mail _____ Birthdate _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Contact Method(s) ☐ Home Phone ☐ Cell ☐ Work ☐ E-mail ☐ Text Message Cell Carrier _____

ALTERNATE RESPONSIBLE PARTY

☐ Legal Guardian ☐ Financially Responsible

Name _____ Relationship to Patient _____

Phone Number [H] _____ [W] _____ [C] _____

E-mail _____ Birthdate _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Contact Method(s) ☐ Home Phone ☐ Cell ☐ Work ☐ E-mail ☐ Text Message Cell Carrier _____

PRIMARY ORTHODONTIC INSURANCE

Name of Insurance _____ Insurance Phone # _____ Group # _____

Name of Subscriber _____ Subscriber's Ins. ID # _____

Subscriber's DOB _____ Relationship of Subscriber to Patient _____

Subscriber's Employer _____ Occupation _____

If different from responsible party please fill out the following information for the insurance subscriber:

Address _____ City _____ State _____ Zip _____

Phone Number _____ Social Security # _____

SECONDARY ORTHODONTIC INSURANCE

Name of Insurance _____ Insurance Phone # _____ Group # _____

Name of Subscriber _____ Subscriber's Ins. ID # _____

Subscriber's DOB _____ Relationship of Subscriber to Patient _____

Subscriber's Employer _____ Occupation _____

If different from responsible party please fill out the following information for the insurance subscriber:

Address _____ City _____ State _____ Zip _____

Phone Number _____ Social Security # _____