

The Offices of Fredrick M. Vega, D.D.S., P.C. & Associates

CHILD REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Father's Name _____ Father's SS # _____ Father's DOB _____

Father's Employer _____

Mother's Name _____ Mother's SS # _____ Mother's DOB _____

Mother's Employer _____

E-mail _____ I would like to receive correspondences via e-mail

Is the patient experiencing any dental problems at this time? If so, what? _____

When was the patient's last dental visit? _____ What was done then? _____

How did you hear about us? _____ Is the child covered by dental insurance? _____

In order to obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In order to get your full complete benefits, we will need the following:

Primary Insurance Information: Name of Insurance Company _____

Address _____ Phone Number _____

Policy Number _____ Group Number _____ Name of Insured _____

Relationship to Insured: Self Spouse Child Other _____

Secondary Insurance Information: Name of Insurance Company _____

Name of Insured _____ SS # _____ DOB _____

Employer Name, Address & Phone _____

Relationship to Insured: Self Spouse Child Other _____

I hereby authorize and request the performance of dental services for _____, age _____ by Dr. Fredrick Vega and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Vega and staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.

(Signature of Responsible Party)

(Relationship to Child)

(Date)