Children's Dental Center of New Hampshire and Orthodontics Too

CHILD'S REGISTRATION

Patient Name: ______________________________ Age: ______ Birth Date: _____/_____/______
First Middle Last

Patient lives with: Both Parents Mother Father Other: ______________________ Gender: Male Female

Father's Name: ______________________________
First Middle Last

Street Address: ______________________________
Town: ____________ State:_____ Zip: ________
D.O.B.:__________ Social Security #: ______________
Home Phone: ______________________________
Work Phone: ______________________________
Mobile Phone: ______________________________
Employer: ______________________________
Employer Address: ______________________________
____
Email: ______________________________

Mother's Name: ______________________________
First Middle Last

Street Address: ______________________________
Town: ____________ State: _____ Zip: ________
D.O.B.:__________ Social Security #: ______________
Home Phone: ______________________________
Work Phone: ______________________________
Mobile Phone: ______________________________
Employer: ______________________________
Employer Address: ______________________________
____
Email: ______________________________

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Subscriber Name: ______________________________
Insurance Co. Name: ______________________________
Group Plan/Employer's Name: ______________________
Insurance Co. Address: ______________________________
____
Insurance Co. Phone #: ______________________________
Group #: ______________________________
Insured ID #: ______________________________

SECONDARY DENTAL INSURANCE

Subscriber Name: ______________________________
Insurance Co. Name: ______________________________
Group Plan/Employer's Name: ______________________
Insurance Co. Address: ______________________________
____
Insurance Co. Phone #: ______________________________
Group #: ______________________________
Insured ID #: ______________________________

As a courtesy to our patients and to ease the billing process for you, we accept assignment of benefits from your insurance carrier. As we deal with your insurance on your behalf, carriers require that we keep your signature on file. Please sign both statements below.

I reviewed the treatment plan(s) and I authorize the release of any information relating to the claim(s).
I hereby authorize direct payment to the above named dentists of the group insurance benefits otherwise payable to me.

X ______________________________
Signature of insured parent / guardian

Payment in full is required at the time of the treatment. The parent who accompanies the child to our office is responsible for payment at the time of service. All office correspondence will be addressed to the child's place of residence. It is important that you keep our office aware of changes in your address, phone numbers, and insurance status. By signing below you understand our office's policies.

X ______________________________ ______________________ ______________
Signature of parent / guardian Relationship to patient Date

Children's Dental Center of New Hampshire and Orthodontics Too

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:______________________________________ Date: _________________________

Signature:____

In the spaces below, please list all children for whom you are responsible:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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