STEINMETZ PEDIATRIC DENTISTRY

PATIENT REGISTRATION FORM

Tell Us About Your Child

Name_____ Nickname_____ Male Female Age_____ Date of Birth_____
SS#_____ Best Contact#_____ School _____Grade_____

Child's Physician _____Physician Phone_____

Child's Home Address_____City_____State_____Zip_____

Hobbies/Interest_____ Child's attitude about Visit_____

Siblings_____ Have they been to our office _____When_____

Child resides with: __ Both Parents ___ Mother__ Father ___other_____

Parent's Marital status: __Married __Divorced __Single ___Widowed ___Separated

Child's Birth History: __Biologic __Adopted at what age_____ Step Child_____
Do you have legal custody of child? Yes No

Parent Information

Father's Name_____ Date of Birth_____ SS#_____

Home Address_____City_____State_____Zip_____

Home#_____Cell#_____Work#_____Email_____

Employer_____Position_____ DL#_____

Mother 's Name_____ Date of Birth_____ SS#_____

Home Address_____City_____State_____Zip_____

Home#_____Cell#_____Work#_____Email_____

Employer_____Position_____ DL#_____

Whom do we contact to schedule /confirm appointments? _____Best#_____

How did you hear about our office?_____

Who is Accompanying child today?_____Relation_____

Permissions to Treat-Since your child is a minor, it becomes necessary that signed permission be obtained from the parent or guardian for any/and or all necessary dental services. I hereby authorize Dr. Stephanie Steinmetz or the dental auxiliaries under direct supervision of the dentist to perform and necessary dental treatment upon my child, including, but not limited to the use of local anesthetic("sleepy drops"), radiographs(xrays) and or Nitrous Oxide("laughing gas").

Signature(parent/Guardian)_____Relation_____ Date_____