Post Oak
Pediatric Dentistry

NEW PATIENT REGISTRATION

Child's name: _____
Last First Middle (Preferred)
Date of Birth: _____ Home Phone: _____-____-_____ Gender: [ ] M, [ ] F
Address _____ City_____ State ____ ZIP _____
Grade _____ Patient's School _____
Other children and their ages: _____
How did you hear about us? _____

Father's name	_____	Mother's name	_____
DOB	_____	DOB	_____
SSN	_____ - _____ - _____	SSN	_____ - _____ - _____
Cell phone	_____	Cell phone	_____
Email	_____	Email	_____
Work phone	_____	Work phone	_____
Employer	_____	Employer	_____

Preferred contact method
Father [ ] Home phone, [ ] Cell phone, [ ] Work phone, [ ] Email
Mom [ ] Home phone, [ ] Cell phone, [ ] Work phone, [ ] Email

Do both parents and child(ren) live together? [ ] Y, [ ] N
Other than parents, is there anyone authorized to bring child(ren) and sign for child's care and treatment?
[ ] Y, [ ] N. (If Y, please complete the below.)
Name _____ Relation to child_____
Cell Phone _____

Is child insured? [ ] Yes, [ ] No

Insurance policy 1
Subscriber Full Name _____ DOB: _____
Subscriber ID: _____ Insurance co. & phone #:_____#:_____
Employer: _____ Group #: _____
Relation to child: _____ **Please present insurance card to the front office**

Insurance policy 2
Subscriber Full Name _____ DOB: _____
Subscriber ID: _____ Insurance co. & phone #:_____#:_____
Employer: _____ Group #: _____
Relation to child: _____ **Please present insurance card to the front office**

Comment