REGISTRATION – CHILD

OOSTBURG FAMILY DENTISTRY
DANIEL R. BRUHN, D.D.S.
JORDAN D. MOLTER, D.D.S.

Today's Date:		
PATIENT INFORMATION		
Child's Last Name:	First:	Middle:
Date of Birth:	Age:	Sex: ❒ M ❒ F
Street Address:		
City:	State:	ZIP Code:
Family members who are patients here:		
How did you learn about our practice?		
INSURANCE INFORMATION: Please present your insurance card to the receptionist.		
Person responsible for payment:	Relationship to child:	
Mailing Address:		
Primary Phone: cell hm	Work Phone:	
Is child covered by a dental plan? **Yes** **No**	Insurance Company:	
Name of Insured:	Insured's Date of Birth:	
Insured's Address (*if different*):		
Insured's Employer:	City:	
Is child covered by a second dental plan? **Yes** **No**	Insurance Company:	
Name of Insured:	Insured's Date of Birth:	
Insured's Address (*if different*):		
Insured's Employer:	City:	
WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?		
Name:	Relationship to child:	
Primary Phone: cell hm	Work Phone:	
AUTHORIZATION		

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance. I authorize Oostburg Family Dentistry and my insurance company to release any information required to process my claims.

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Parent or Guardian Signature Date

revised July 2023