Golden Valley Kids
Pediatric Dentistry & Orthodontics

REGISTRATION

DATE _____

CHILD'S FULL NAME _____ DATE OF BIRTH _____

MALE _____ FEMALE_____

ADDRESS_____ CITY _____ STATE_____ ZIP_____

SCHOOL _____ GRADE _____ INTERESTS_____

PARENT NAME _____ PARENT NAME _____

EMPLOYER _____ EMPLOYER _____

HOME PHONE _____ HOME PHONE _____

CELL PHONE _____ CELL PHONE _____

EMAIL _____ EMAIL _____

PARENT'S MARITAL STATUS: ___S ____M ____W ____D

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

PRIMARY DENTAL INSURANCE _____ POLICY HOLDER_____

ID# _____ GROUP # _____ BIRTHDATE _____

SECONDARY DENTAL INSURANCE_____ POLICY HOLDER ____ _____

ID# _____ GROUP # _____ BIRTHDATE _____

MEDICAL INSURANCE: COMPANY _____ POLICY HOLDER NAME _____

DENTAL HISTORY

FIRST DENTAL VISIT? _____ FORMER DENTIST _____ LAST SEEN _____

DATE OF LAST DENTAL X-RAYS _____ DOES YOUR CHILD USE (CIRCLE) THUMB/PACIFIER?

DO YOU HAVE (CIRCLE): CITY WATER WELL WATER PURIFIED WATER

DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S TEETH? _____

TOOTHBRUSHING HABITS _____ DO YOU ASSIST? _____

DESCRIBE YOUR CHILD'S EATING HABITS _____

HISTORY OF DIFFICULT OR NEGATIVE DENTAL EXPERIENCES _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

I HEREBY AUTHORIZE ALL NECESSARY DENTAL SERVICES AND RADIOGRAPHS BE RENDERED FOR:

PATIENT NAME: _____ PARENT SIGNATURE: _____ DATE: _____