DENTAL ARTS
ASSOCIATES OF GREEN BAY LTD
www.dentalartsofgreenbay.com

Child Patient Registration Form

Patient's Name _____ _____ Date of Birth _____ Gender M / F

Address _____ _____ Phone #____ _____

City _____Zip _____ Nickname_____

School _____ Referred by_____

Parent/Guardian Information

Father's Name_____ Mother's Name_____

Address_____ Address_____

City_____Zip_____ City_____Zip_____

Employer_____Work #_____ Employer_____Work #_____

Who will pay for this account? _____

Insurance Information

Dental Insurance Company #1

Insurance Company _____Phone # ( )_____

Family Coverage___ Single Coverage___ Self & Spouse___ Self & Children___

Employee_____ Employee Date of Birth _____

Relationship to Patient _____ Employer _____

Insured SS# _____-_____-_____ Insured ID# _____

I hereby authorize payment directly to Dental Arts Assoc., Ltd unless otherwise specified.

Group# _____

_____ _____

(Signature) (Date)

Dental Insurance Company #2

Insurance Company _____ Phone # ( )_____

Family Coverage___ Single Coverage___ Self & Spouse___ Self & Children___

Employee_____ Employee Date of Birth _____

Relationship to Patient _____ Employer _____

Insured SS# _____-_____-_____ Insured ID# _____

I hereby authorize payment directly to Dental Arts Assoc., Ltd unless otherwise specified.

Group# _____

_____ _____

(Signature) (Date)