Natural Smiles Dental Care

*Child Registration

3434 Lexington Ave N Suite 700
Shoreview, MN 55126
contact@naturalsmilesdental.com

*Today's Date:*_____

Patient name:_____
*Nickname preferred:*_____
*Birthdate:*_____ *Male* ___ *Female*___
*School:*_____
*Home address:*_____
_____
*Phone:*_____
*Mom Cell #:*_____ *Work #:*_____
*Dad Cell #*_____ *Work #:*_____

Dental coverage? *Yes*____ *No*_____
*Insurance Company:*_____
*Insured's Name:*_____
*Insured's Birthdate:*_____
*Insured's ID #*_____
Group # _____
*Insured's Employer:*_____

*Contact Email:*_____

*How did you hear about us?*_____

*Previous DDS:*_____
Person responsible for Account:
_____

Any 2nd Insurance coverage? *Yes*____ *No* ____
*Insurance Company:*_____
*Insured's Name:*_____
*Insured's Birthdate:*_____
*Insured's ID#*_____
*Group #:*_____
*Insured's Employer:*_____

*Parents' names:*_____
_____

Payment is due in full at time of treatment. I understand that I am responsible for payment of services rendered and also am responsible for paying any co-payment and deductible estimates at each appointment that insurance does not cover. I hereby authorize payment directly to Natural Smiles Dental Care otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination, to my insurance company.

Parent Print Name: _____ *Date:*_____

Signature: _____ *Date:*_____