

CHILD REGISTRATION

PLEASE COMPLETE BOTH SIDES AND BRING THIS FORM WITH YOU AT THE TIME OF YOUR INITIAL VISIT.

Patient Name _____ Maiden _____

Patient Address _____ City _____ State _____ Zip _____

Patient Home Phone _____ Work _____ DOB _____ Age _____ M/F _____

Family Dentist _____ Referred By _____

Reason for Consultation _____

Parent Information

Mother _____ Maiden _____ SS# _____

Address _____ City _____, Zip _____

Employer _____ Occupation _____

Home Phone _____ Work _____ Contact Y/N _____

Orthodontic Insurance Y/N _____ Name of Insured _____ DOB _____

Name of Insurance Co. _____, ID _____ Group _____

Address _____, City _____, Zip _____

Father _____ SS# _____

Address _____ City _____ Zip _____

Home Phone _____ Work _____ Contact Y/N _____

Employer _____ Occupation _____

Orthodontic Insurance Y/N _____ Name of Insured _____ DOB _____

Name of Insurance Co. _____, ID _____ Group _____

Address _____, City _____, Zip _____

X _____

Signature of Financially Responsible Party (Party who is requesting treatment)

Visit our Website at www.kirschorthodontics.com

Email us at: kirsch@kirschorthodontics.com