

**Meeuwsen Dental PLLC
dba Kent City Dental Center
CHILD/MINOR REGISTRATION
(Confidential)**

Date: _____

PATIENT INFORMATION

Name of Minor Child: Last _____ First _____ MI _____
Sex M F Age _____ Birthdate _____ Nickname (if any) _____
Home Address _____
Person Financially Responsible _____ Relationship to child _____
Billing Address _____
Home phone _____ Work phone _____ Cell _____
Email address _____

Whom may we thank for referring you to us? _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name: Last _____ First _____ MI _____
Relationship to patient _____ Birthdate _____ Soc Sec # _____
Address (if different from child) _____
Subscriber Employed By _____ Occupation _____
Subscriber Address _____ Business Phone _____
Dental Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name: Last _____ First _____ MI _____
Relationship to patient _____ Birthdate _____ Soc Sec # _____
Address (if different from child) _____
Subscriber Employed By _____ Occupation _____
Subscriber Address _____ Business Phone _____
Dental Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____

EMERGENCY CONTACTS

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

Phone _____

Name _____ Relationship _____

Phone _____

Please list any other persons with whom we may discuss/disclose your child's dental treatment and/or communicate information protected by HIPAA, if any:

Name(s) and relationship(s) to child _____
