DUKE CHILDREN'S Hospital & Health Center

PEDIATRIC DENTISTRY

Patient Registration

please print all information clearly

PATIENT'S NAME Last	First	Middle	Nickname
DATE OF BIRTH Month Day Year		SEX (Check One) ☐ Female ☐ Male	
HOME ADDRESS (Number, Street, Route, Etc.)			
CITY		STATE	ZIP
HOME PHONE ( ) –		PATIENT'S SOCIAL SECURITY NUMBER – –	

PLEASE PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18 YEARS OR HAS A LEGAL GUARDIAN

FATHER Last	First	Occupation	Daytime phone ( ) –
MOTHER Last	First	Occupation	Daytime phone ( ) –
MARTIAL STATUS OF PARENTS (Check one) ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED			
WITH WHOM DOES PATIENT LIVE?			
NAME OF LEGAL GUARDIAN Last	First	Occupation	Daytime phone
WHOM DO WE CONTACT TO SCHEDULE APPOINTMENTS? Last	First	Daytime phone ( )	Evening phone ( )

GUARANTOR INFORMATION (PARENT/GUARDIAN ACCOMPANYING PATIENT):

GUARANTOR NAME Last	First	Middle	SOCIAL SECURITY NUMBER	DATE OF BIRTH
MAILING ADDRESS (if different from patient) Number, Street, Box, Etc.)			STATE	ZIP
			HOME #	WORK #
DENTAL INSURANCE POLICY HOLDER Last (Number, Street, Box, Etc.)	First	Middle	SOCIAL SECURITY NUMBER	DATE OF BIRTH
			HOME	WORK #
EMPLOYER'S NAME AND ADDRESS IF INSURED			STATE	ZIP
DENTAL INSURANCE COMPANY NAME AND ADDRESS			STATE	ZIP
DENTAL INSURANCE COMPANY'S GR # POL #			PHONE	
PAYMENT METHOD (CHECK ONE) CASH ☐ CHECK ☐ INSURANCE ☐ VISA ☐ MASTERCARD ☐			GUARANTOR'S DRIVER'S LICENSE NUMBER	

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

NAME OF PERSON COMPLETING THIS FORM _____ / _____

NAME DATE