

Vanover Dentistry of Orange Park
Implant - Family Care - Cosmetic

Patient Registration – Welcome to Our Office

About Your Child

Today's Date: _____
Child's Name: _____
Last First MI
Prefers to be called: _____ Male Female
Child's Birthday: ___/___/___ Age: _____
School: _____ Grade: _____
SS#: _____ - _____ - _____
Child's Home ph#: _____
Home Address: _____
Zip: _____
Child lives at home of:
 Mom Dad Grandparent Guardian/Other
Child's Parents:
 Single Married Divorced Widowed Separated
Who may we thank for referring you?

Other family members seen by us:

Previous Dentist: _____
Last Visit Date: _____

Dental Insurance

Insurance Co Name: _____
Insur. Co Phone#: _____
Policy Holder's (Subscriber) Information
Subscriber's Name: _____
Insurance ID #: _____ Group #: _____
Subscriber's SS#: _____ - _____ - _____
Subscriber's DOB: ___/___/___
Subscriber's Relation to Patient: _____
Subscriber's Employer: _____

Adult accompanying the child today

Name: _____
Relation to Child: _____
Are you a legal guardian of child? Yes No
Emergency Contact: _____ Ph#: _____

Mother's Information Stepmother Guardian

Name: _____
Work#: _____ Home#: _____
Employer: _____ Cell#: _____
SS#: _____ - _____ - _____ DOB: _____

Father's Information Stepfather Guardian

Name: _____
Work#: _____ Home#: _____
Employer: _____ Cell#: _____
SS#: _____ - _____ - _____ DOB: _____

Your Contact Preferences

Email: _____
Best way to be reached: (Please circle all that apply)
Home Ph | Work Ph | Cell Ph | Email | Text Message
Best way to be reminded of appointments:
Home Ph | Work Ph | Cell Ph | Email | Text Message

Your Child's Dental History

Has had difficulty with previous dental treatment? Yes No
Home water is fluoridated? Yes No Well water/City water
Presently uses bottle or sippy cup? Yes No
Brushes 2/day? Yes No Floss regularly? Yes No
Currently sucks finger or uses pacifier? Yes No
Recent Toothaches or Jaw pain? Yes No
What are your concerns about your child's oral health? _____

I understand that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in strict confidence and that it is my responsibility to inform office of any changes in insurance, and/or medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

I understand that payment for all treatment is ultimately my responsibility regardless of insurance coverage. I authorize the release of any information required to process my dental insurance and payment to be sent directly to this office. If this account is sent to collections, I agree to pay all associated costs incurred. Payment is due in full at time of treatment unless prior arrangements have been approved.

X _____
Parent/Guardian Signature Date