Camino Pediatric Dentistry
Patient Registration Form

Contact Information				
Home Address				
Home Telephone				
Patient Information				
Child 1	First Name:	Last Name:	Nickname:	
	Age	Birthday / /	Gender: Boy Girl	
Child 2	First Name:	Last Name:	Nickname:	
	Age	Birthday / /	Gender: Boy Girl	
Child 3	First Name:	Last Name:	Nickname:	
	Age	Birthday / /	Gender: Boy Girl	

Parent Information			
Father		Mother	
Name		Name	
Birth date / /		Birth date / /	
Occupation		Occupation	
Employer		Employer	
Business Phone		Business Phone	
Cell Phone		Cell Phone	
Email		Email	
Preferred Contact Method			
Insurance Information			
Primary Coverage		Secondary Coverage (if applicable)	
Subscriber Name		Subscriber Name	
Home Address		Home Address	
Social Security		Social Security	
Insurance Carrier		Insurance Carrier	
Group Name	Group #	Group Name	Group #
Miscellaneous			
Whom may we thank for referring you to our office?			

I authorize routine dental procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and diagnostic x-rays considered necessary by the dentist for the comfort, health, and well being of my child.

Legal Guardian (print): ____

Legal Guardian Signature: _____________________________ Date: __________