Michael D. Vanover, D.D.S., P.A.
General & Cosmetic Dentistry For All Ages

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: _____________________________

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

Dental Insurance

Insurance Co Name: ________________________
Insur. Co Phone#: __________________________
Policy Holder's (Subscriber) Information
Subscriber's Name: _________________________
Member ID #: ______________________________
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#:___________

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