REGISTRATION FORM

Demographic Information

Patient's Name: ____ Patient's SSN:________/______/________
(FIRST) (MIDDLE) (LAST)

Nickname:____________________________ Date of Birth:_____________________________ Sex:___________

Home Address:____
Street Address Town State Zip Code

School:____ Grade:_____________

Do we see other children in your family? ☐Yes ☐No Names:____

Whom may we thank for referring you to us?____

What is the reason for your child's dental visit?____

Treatment Authorization/Financial Agreement

Father's Name:__________________________________ Employed By:______________________________________

Home Phone:_____________________ Work/Cell Phone:_________________ E-mail:________________________

Mother's Name:_________________________________ Employed By:______________________________________

Home Phone:_____________________ Work/Cell Phone:_________________ E-mail:________________________

Child lives with: ☐Both Parents ☐Mother ☐Father ☐Other_____________________________

Parents' marital status: ☐ Married ☐Divorced ☐Single ☐Widowed

Name of Primary Dental Insurance Co.:__________________________________ Group #:_____________________

SSN of insured: ________/_______/__________ Date of Birth of insured: ____________________________

Name of Secondary Dental Insurance Co.:________________________________ Group #:_____________________

SSN of insured: _______/_______/___________ Date of Birth of insured: ____________________________

Person responsible for payment:____

Person to be contacted in case of emergency (other than parents):

Name:________________________________ Relation:________________________ Phone:___________________

Appointment & Cancellation Policies

One parent is permitted to remain with each child during treatment (other than sedation appointments). Dr. Jackson, Dillow or Day will discuss with you the terms and conditions for this privilege. Other guests/siblings must remain in the waiting room accompanied by an adult.

We request that 24-hour notice be given if you cannot bring your child for their scheduled appointments. You will be charged $25.00 for broken appointments when illness is not a factor and 24-hour notice is not given.

I have read and fully understand the above **APPOINTMENT & CANCELLATION POLICIES** and accept all provisions.

Parent's/Guardian's Signature:____ Date:_____________________

Relationship to patient:____

Rodney A. Jackson, D.M.D. • Morgan C. Dillow, D.M.D. • R. Michael Day, D.M.D.
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