

# 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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