

CHILD REGISTRATION FORM

Child's Name _____ Date _____
 First Middle Last
Nickname _____ Sex _____ Race _____ Age _____ Birthdate _____
Address _____ Phone _____
 Street City State Zip
School _____ Grade (K-12) _____ Overall grade average (A B C D)
Interests and hobbies _____ Favorite subjects _____

Father's name _____ Father:
Address _____ Single _____
 Street City State Zip
Age _____ Date of birth _____ Home phone _____ Married _____
Occupation _____ Employed by _____ Divorced _____
Business address _____ Bus. phone _____ Separated _____
Present position _____ How long held _____ Widowed _____
Father's Social Security number _____ Remarried _____

Mother's name _____ Mother:
Address _____ Single _____
 Street City State Zip
Age _____ Date of birth _____ Home phone _____ Married _____
Occupation _____ Employed by _____ Divorced _____
Business address _____ Bus. phone _____ Separated _____
Present position _____ How long held _____ Widowed _____
Mother's Social Security number _____ Remarried _____

Person(s) financially responsible for orthodontic treatment? _____
Do you have insurance that may cover any part of our professional services? _____
If yes, name of company _____ Policy No. _____
Is policy connected with your union? _____ If yes, name of union _____
Local No. _____ Group No. _____ Policy holder _____
(It is necessary for you to provide claim forms for all professional services that may be eligible for insurance coverage. Ask for details at desk).

Other children in family (Names and ages) _____
In case of emergency, whom should be notified? _____ Phone _____
Whom may we thank for referring your child? _____
If not referred, how did you hear about our office? _____