ReGenesis Health Care
Family Dentistry

## PEDIATRIC REGISTRATION FORM

1 **Patient Name** _____ **Date of Birth** _____ **Age** _____
*Last First Middle*

2 **Sex** □Male □Female **Social Security #** _____

3 **Mailing Address** _____ Apt/Suite _____

City _____ State _____ Zip Code _____

Phone # _____ Cell# _____ Best way to reach you? □Home □Cell

4 **Martial Status** □Single □Married □Divorced □Separated □Widowed □Other

5 **Emergency Contact** _____ Phone# _____

Relationship to Patient _____

6 **Ethnic Group** □American Indian/Alaska Native □Asian □Black/African-American □Hispanic/Latino □Native Hawaiian □Other Pacific Islander □Refused to Report □White

7 **Language:** □English □Sign Language □Spanish □Other (please list language)_____

8 **Characteristics**: □Migrant Worker □Seasonal Worker □Homeless □Homeless Shelter □Transitional/Visiting □Multiple Family Household □Unknown □Other

9 **Referral Source (How did you hear about us?):** □ Health Fair/Event □ Relative/Friend □ Newspaper □ Phone Book □ Internet □ Hospital/Agency/Physician _____
*Name of hospital/agency/physician*

***For Informational Purposes Only***

10 Are you a Veteran? □ Yes □ No Annual Household Income _____ Family Size _____

11 **PATIENT(PARENT/GUARDIAN) EMPLOYMENT INFORMATION**

Employment Status: □Full-time □Part-time □Unemployed □Retired □Seasonal □Migrant
Student: □Full-time □Part-time

Employer _____
Address _____
City/State _____ Zip Code _____
Employer Phone # _____ Can we contact you at work: □Yes □No

12 **INSURANCE INFORMATION**

*Co-payments are required at time of visit and/or payment for services not covered by insurance.

□Private Insurance □Self Pay □Workers Comp □Disabled □Other
□Medicare# _____ □Medicaid# _____
Insurance Company _____ Insured's Name _____
Group# _____ Policy# _____
SS# _____ DOB _____
Employer _____ Employer Phone # _____
Employer Address _____ City/State/Zip _____

*I authorize the release of any required medical information from my record to the above insurance company in order to process my claim.

_____
*Signature of Patient, Guardian or Legal Representative / Date*

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ReGenesis Health Care will only communicate information regarding your care, or that of your minor child, to those inidviduals that you have authorized. Please list below the names of any relatives, as well as their relationship to you, that you authorize ReGenesis Health Care to communicate with regarding your care.

**I AUTHORIZE THE SHARING OF MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS:**

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Patient(Parent/Guardian)Signature_____ Date: _____

**How would you like to be contacted regarding appointments, treatment, or other information pertaining to your care?**

____Mail ____Home Phone ____Work Phone

If you have an answering machine, may we leave a nonspecific message regarding appointments, or other information pertaining to your care? ____Yes ____No

If you do not authorize the use of any of these methods, then please list any alternate method we may use in contacting you: _____

Patient(Parent/Guardian)Signature_____ Date: _____