

# 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 **Marital 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# \_\_\_\_\_

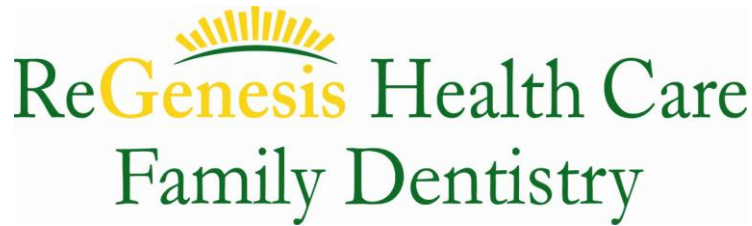
SS# \_\_\_\_\_ DOB \_\_\_\_\_

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



ReGenesis Health Care  
Family Dentistry

ReGenesis Health Care will only communicate information regarding your care, or that of your minor child, to those individuals 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: \_\_\_\_\_

