Patient Registration Form

Patient's Full Name	Birthday	Age	Gender	Relationship to Guardian

Family Information:

Parent/Guardian	Parent/Guardian
Name:	Name:
SSN:	SSN:
Address:	Address:
City, State, Zip:	City, State, Zip:
Cell Phone:	Cell Phone:
Home Phone:	Home Phone:
Date of Birth:	Date of Birth:
Email:	Email:
Marital Status:	Marital Status:

Preferred Contact Method: Text Email Phone

Dental Insurance: (if you do not have insurance, please leave blank and/or inquire about our in-office membership plan!)

Primary Insurance	Secondary Insurance
Subscriber Name:	Subscriber Name:
Name of Insurance:	Name of Insurance:
Insurance Phone #: Group #: ID #:	Insurance Phone #: Group #: ID #:
Employer:	Employer:

How did you hear about us? _____

KSPD accepts most dental insurance plans. For your convenience, we send a dental claim to your insurance company after your child receives treatment. Your insurance company is obligated to pay the claim within 60 days from the date of submission. Claims unpaid after 60 days become your responsibility. You will be sent a statement showing the unpaid claims and/or your financial responsibility after all claims have been processed by your insurance provider.
By signing below, you consent to your child's treatment and your financial obligation to Kinder Smiles Pediatric Dentistry. I understand that I am responsible for any charges that are reasonably denied or unpaid by my insurance company.

_____

Parent/Legal Guardian Signature* Date

*If you are filling out this form prior to your visit, your electronic/typed signature is equivalent to your written signature.
Please email completed forms to colin@kindersmilesco.com