



Growing Smiles Pediatric Dentistry
New Patient Registration Form

Child's Full Name Male/Female Age Birthdate
Address/Zip Phone
Child's Social Security # Add sibling's information to back of this page.

Father's Name Address
Phone # Birthdate Social Security #
Occupation Employer Work Phone #
Name of Father's Dental Insurance
Group Number Cell Phone #
Email Address

Mother's Name Address
Phone # Birthdate Social Security #
Occupation Employer Work Phone #
Name of Mother's Dental Insurance
Group Number Cell Phone #
Email Address

In case of emergency, whom should we notify?
Person(s) Financially Responsible
Has your child been seen in this office before? When?
Names/Ages of Brothers/Sisters
Whom may we thank for referring you?
Has your child been to the dentist before? If so, who?
When Reason Were x-rays taken?
Is your child currently experiencing dental pain? Reason
Have there been any injuries to the mouth? When
Does your child have any habits? (Circle) Bottle Thumb/finger sucking Pacifier Other
Does your child brush/floss daily? Do you assist? Is your water from a well?
Are you happy with the appearance of your child's teeth?
Does your child participate in sports?
Do you have any other concerns?

I authorize release of any information relating to this claim.

I hereby authorize payment to the dentist.

Signed (Patient or Parent if Minor)

Date

Signed

Date

Child's Full Name _____ Male/Female ___ Age ___ Birthdate _____
Child's Social Security # _____
Has your child been to the dentist before? _____ If so, who? _____
When _____ Reason _____ Were x-rays taken? _____
Is your child currently experiencing dental pain? _____ Reason _____
Have there been any injuries to the mouth? _____ When? _____
Does your child have any habits? (Circle) Bottle Thumb/finger sucking Pacifier Other
Does your child brush/floss daily? _____ Do you assist? _____
Are you happy with the appearance of your child's teeth? _____
Does your child participate in sports? _____
Do you have any other concerns? _____

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Do you have any other concerns? _____