

*Pediatric Registration*

Linh T. Tran, DDS, PC

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle

Male  Female Birthdate \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age \_\_\_\_ Grade \_\_\_\_

Home Address: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home#: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Who is accompanying the child today? Name \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

PARENTS INFORMATION (  Mother  Father  Stepmother  Stepfather  Guardian)

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

IN THE EVENT OF AN EMERGENCY, whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_ Home/Work Phone #: \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

Relation: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

SS #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

PRIMARY DENTAL INSURANCE CO. NAME: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_

ASSIGNMENT & RELEASE: I, the undersigned, assign directly to Linh T. Tran, DDS, PC all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether financial or electronic. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parent/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for any charges not covered by insurance.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date