

The Offices of Fredrick M. Vega, D.D.S., P.C. & Associates

CHILD REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

Patient Last Name First Name Middle Initial

Address City State Zip Code

Home Phone Cell Phone Work Phone

Father's Name Father's SS # Father's DOB

Father's Employer

Mother's Name Mother's SS # Mother's DOB

Mother's Employer

E-mail I would like to receive correspondences via e-mail

Is the patient experiencing any dental problems at this time? If so, what?

When was the patient's last dental visit? What was done then?

How did you hear about us? Is the child covered by dental insurance?

In order to obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In order to get your full complete benefits, we will need the following:

Primary Insurance Information: Name of Insurance Company

Address Phone Number

Policy Number Group Number Name of Insured

Relationship to Insured: Self Spouse Child Other

Secondary Insurance Information: Name of Insurance Company

Name of Insured SS # DOB

Employer Name, Address & Phone

Relationship to Insured: Self Spouse Child Other

I hereby authorize and request the performance of dental services for, age by Dr. Fredrick Vega and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Vega and staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.

(Signature of Responsible Party)

(Relationship to Child)

(Date)