Welcome to Power Road Dental Care

Child Registration

Patient____
First Middle Last

Sex: M___F___ Birthdate____________ Age______ Social Security #______________

Mother's name________________________ Father's name______________________
Address______________________________ Address____________________________
_____________________________________ ___________________________________
Home Ph #___________________________ Home Ph #__________________________
Cell Ph #____________________________ Cell Ph #___________________________
Employer____________________________ Employer__________________________
Work Ph #___________________________ Work Ph #__________________________

Who does this child live with?____
What is the purpose of this appointment?_____________________________________
When and where was the child's last dental visit?______________________________
Names of brother's and sisters____

Primary Dental Insurance Information

Subscriber's name____
Subscriber's address____
Subscriber's SS#___________________________ Birthdate______________________
Relationship to patient____
Subscriber's employer____
Business address and phone____
Insurance Company________________________ Phone #________________________
ID#______________________________________ Group #________________________

Secondary Dental Insurance Information

Subscriber's name____
Subscriber's address____
Subscriber's SS#___________________________ Birthdate______________________
Relationship to patient____
Subscriber's employer____
Business address and phone____
Insurance Company________________________ Phone #________________________
ID#______________________________________ Group #________________________

In case of an emergency who should be notified? Please give name and phone number.

Relative____
Non-Relative____