Joseph C. Ardizzone, D.D.S.
30317 16th Avenue So
Federal Way, WA 98003

CHILD REGISTRATION FORM

Please Print

Patient's Name ________________________ Birthdate __________________
Address_________________________ City ________ ZIP _______________
Social Security Number _____-_____-______ Male __Female______________
Home Phone ___________________________
Person Responsible for this account ____ Mother ____ Father ___ Other
Does the child live with the person responsible for this account? Yes / No (circle one)

If Other, list name:
____
Relationship to patient:
____
Address (if different than above)
____
City __________________State _________ZIP_________________
Home Phone __________BusinessPhone______________________

Mother's Name________________________ Birthdate __________________
Social Security Number _____-_____-______ Driver's License # __________
Employed by ____________________________ Present Position____________
Employer's Address ______________________ City __________ ZIP_________
Home Phone ____________________________ Business Phone_____________
Dental Insurance Co ______________________ Group/Policy #_____________
Is the patient covered by the mother's plan? Yes / No (circle one)

Father's Name__________________________ Birthdate ___________________
Social Security Number _____-_____-______ Driver's License#____________
Employed by ____________________________ Present Position____________
Employer's Address ______________________ City ___________ ZIP________
Home Phone _____________________ Business Phone_____________________
Dental Insurance Co ______________________ Group/Policy #_____________
Is the patient covered by the father's plan? Yes / No (circle one)
Whom may we thank for referring you to our office?_____________________

All professional services are charged to the patient or patient's guardian. Necessary forms will be completed to expedite insurance carrier payments. The patient or patient's guardian is responsible for all fees, regardless of insurance coverage.

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies.

I hereby authorize payment directly to Dr. Joseph C. Ardizzone of the insurance benefits otherwise payable to me. I understand I am financially responsible for any charges not paid by my insurance company(s).

Parent/Guardian Signature _________________________ Date_____________