HENDRICKS PEDIATRIC DENTISTRY 1411 S. GREEN STREET, #200 BROWNSBURG, IN 46112
Ph: (317) 852-8113 Fax: (317) 852-8115

PATIENT REGISTRATION

Patient Name_____ Birth date_____/_____/_____
(First) (Middle) (Last) (Month/Day/Year)

Nickname/Preferred to be called_____ Social Security #_____-_____-_____

Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _____

Any Dental Concerns or any additional information we should be aware of? _____

_____

_____

Address _____ City _____ Zip _____

Preferred Phone # (_____)_____ Email: _____

Patients live with (circle one) (both parents), (grandparents), (single parent) (Other) _____

*****The person who brings the child is the responsible party for consent of treatment and payments.***

Previous Dentist

Has patient been to a dentist in the past? YES NO (if NO, skip dentist information)

Dentist Name _____ Phone (____)_____

Address _____

Were any X-rays taken? YES NO Date of last cleaning/Fluoride Treatment____/____/_____

Guardian Information

Name _____
(First) (Middle Int.) (Last)

Relationship to patient _____

Soc.Sec. # _____

Birth date _____/_____/ _____

Address _____
(If different from above) (Street)

_____
(City) (State) (Zip code)

Phone: (Home) (___) _____
(Work) (___) _____
(Cell) (___) _____

Employer: _____

Employer Address: _____

Additional Guardian Information

Name _____
(First) (Middle Int.) (Last)

Relationship to patient: _____

Soc. Sec. # _____

Birth date _____/_____/ _____

Address _____
(If different from above) (Street)

_____
(City) (State) (Zip code)

Phone: (Home) (___) _____
(Work) (___) _____
(Cell) (___)_____

Employer: _____

Employer Address: _____

Emergency Contact: Name:_____ Phone: (___)_____

Dental Insurance: YES NO **MEDICAID:** Certificate #_____

PRIMARY

Subscriber name: _____ Subscriber D.O.B. _____/_____/_____

Subscriber Soc. Sec. #_____ Subscriber ID# _____

Group Name: _____ Group #: _____

Insurance Company Name: _____ Insurance Company Phone # _____

Insurance Company Address: _____

SECONDARY

Subscriber name: _____ Subscriber D.O.B. _____/_____/_____

Subscriber Soc. Sec. #_____ Subscriber ID# _____

Group Name:_____ Group #: _____

Insurance Company Name: _____ Insurance Company Phone # _____

Insurance Company Address: _____

Whom can we thank for referring you to our practice? _____

Additional Patients

Patient Name____ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called_________________________ Social Security #_____-_____-______
Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _________________________
Any Dental Concerns or any additional information we should be aware of? ________________________
____

Patient Name____ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called_________________________ Social Security #_____-_____-______
Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _________________________
Any Dental Concerns or any additional information we should be aware of? ________________________
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Patient Name____ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called_________________________ Social Security #_____-_____-______
Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _________________________
Any Dental Concerns or any additional information we should be aware of? ________________________
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(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called_________________________ Social Security #_____-_____-______
Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _________________________
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(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called_________________________ Social Security #_____-_____-______
Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _________________________
Any Dental Concerns or any additional information we should be aware of? ________________________
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(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called_________________________ Social Security #_____-_____-______
Sex: M / F **Ethnicity**: White / Black / Hispanic / Other: _________________________
Any Dental Concerns or any additional information we should be aware of? ________________________
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Additional Notes: ____
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