Welcome to Crockett Pediatric Dentistry, P.A.
Patient Registration Information

Patient Information

Patient's Name _____ Name child goes by _____ Gender ___
First Middle Last

Mailing Address _____
Street City State Zip

Date of Birth: _____ Age: _____ Weight _____ Patient's SSN _____

Child Lives with: Both Parents _____ Mother _____ Father _____ Other _____

Names of Brothers or Sisters _____ School Name _____

Patient's Physician or Pediatrician Name _____ Family Dentist _____

How did you hear about our office? _____

E-mail address: _____

Responsible Party Information

Mother

Name _____ Marital Status _____

Address (if different from above) _____

Social Security Number _____ Birth Date _____ Occupation _____

Employer _____

Home Phone _____ Work Phone _____ Cell Phone _____

Father

Name _____ Marital Status _____

Address (if different from above) _____

Social Security Number _____ Birth Date _____ Occupation _____

Employer _____

Home Phone _____ Work Phone _____ Cell Phone _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. No. _____

Primary Insured's Home Address _____

Insured's Birth Date _____ Insurance Co. _____ Group No. _____

Subscriber No. _____ Insurance Co. Address _____

Phone No. _____ Primary Insured's Employer _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above names dental entity.

Signed Employee/Subscriber- _____