experience • excellence

PEDIATRIC SANDERS DENTISTRY

PATIENT REGISTRATION

Patient Name:_____ Date of Birth:_____ Gender: ☐ Male ☐ Female

Street Address:_____ Race:_____

City:_____ State:_____ Zip Code:_____ Home Phone:_____

Sibling(s):_____

How were you referred to our office? _____

Martial Status: ☐ Divorced ☐ Married ☐ Single ☐ Other

Parent/Guardian 1:_____

SSN:_____ Date of Birth:_____ Employer:_____

Address:_____ City:_____ State:_____

Zip Code:_____ Cell Phone: _____ Email Address:_____

Parent/Guardian 2:_____

SSN:_____ Date of Birth:_____ Employer:_____

Address:_____ City:_____ State:_____

Zip Code: _____ Cell Phone: _____ Email Address:_____

Emergency Contact Name:_____

Relationship to Patient:_____ Phone:_____

Insurance Coverage Information

Insurance Company: _____ Employer:_____

Name of Insured: _____ Relationship to Patient: ☐Parent ☐ Self

Insurance Group ID #: _____ Subscriber ID#:_____

Parent/Guardian Signature:_____ **Date:**_____

13590-B N. Meridian St. Suite 202 • Carmel, IN 46032 • Tel. 317.818.2200 • Fax: 317.818.0555
sanderspediatricdentist.com