COLLEGE OF DENTISTRY
The UNIVERSITY *of* OKLAHOMA HEALTH SCIENCES

PEDIATRIC DENTISTRY SPECIALTY CLINIC: PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Full Legal Name (First Middle Last)

Name patient prefers to be called | Date of Birth | Gender

Reason for Today's Visit

Referral Source, if applicable

Preferred Language

RESPONSIBLE PARTIES

Name of Legal Guardian #1 | Relationship to Patient

Address (Street, City, State, Zip)

Phone (Cell / Home – *circle one*) | Email Address

Employer | Occupation

Name of Legal Guardian #2 | Relationship to Patient

Address (Street, City, State, Zip)

Phone (Cell / Home – *circle one*) | Email Address

Employer | Occupation

PRIMARY DENTAL INSURANCE INFORMATION

Full Name of Insured Party _____ Relationship to Patient _____

Insured's SSN / Member ID _____ Insured's Date of Birth _____

Insurance Company's Address (Street, City, State, Zip) _____

SECONDARY DENTAL INSURANCE INFORMATION

Full Name of Insured Party _____ Relationship to Patient _____

Insured's SSN / Member ID _____ Insured's Date of Birth _____

Insurance Company's Address (Street, City, State, Zip) _____

MEDICAL INSURANCE INFORMATION

Full Name of Insured Party _____ Relationship to Patient _____

Insured's SSN / Member ID _____ Insured's Date of Birth _____

Insurance Company's Address (Street, City, State, Zip) _____

EMERGENCY CONTACT INFORMATION *(someone not listed above as guardian)*

Full Name _____ Relationship to Patient _____

Emergency Phone _____ Emergency Address (Street, City, State, Zip) _____