CACHE VALLEY PEDIATRIC DENTISTRY

DAREN F. GEHRING, DDS
1624 North 200 East, Suite 100
Logan, UT 84341
Phone: (435) 752-4330

PATIENT REGISTRATION FORM

PATIENT CONTACT INFORMATION

CHILD'S NAME _____ _____ SEX ◯ Male ◯ Female
First Name Last Name Preferred Name

AGE _____ BIRTHDAY ____ / ____ / _____ SCHOOL _____ GRADE _____
MM DD YYYY

ADDRESS - Mailing _____
Street Name/Number City State Zip

ADDRESS - Physical _____
Street Name/Number City State Zip

PHONE NUMBER (_____) _____ SECONDARY PHONE - Optional (_____) _____

EMERGENCY CONTACT (Outside of Your Home) _____
First Name Last Name

_____
Relationship to Patient Phone Number

PATIENT FAVORITES - INTERESTS - HOBBIES - ETC.

COLOR _____ BOOK _____ MOVIE/CHARACTER _____

PETS - Type & Name _____ SPORTS PLAYED _____

INSTRUMENTS PLAYED _____ HOBBIES _____

FUN FACTS ABOUT YOUR CHILD _____

_____

HOW DID YOU HEAR ABOUT US?

◯ Newspaper ◯ Website ◯ Physician's Office (Name Below) ◯ Phone Book ◯ Facebook ◯ Radio

◯ School ◯ Dental Office ◯ Family/Friend (Name Below) ◯ Hometown Values ◯ Web Search ◯ Other

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____
Provider Name

ID# _____ GROUP# _____

INSURED'S NAME _____

SSN _____ BIRTHDAY ____ / ____ / _____
MM DD YYYY

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____
Provider Name

ID# _____ GROUP# _____

INSURED'S NAME _____

SSN _____ BIRTHDAY ____ / ____ / _____
MM DD YYYY

RELATIONSHIP TO PATIENT _____

PARENT INFORMATION

MOTHER'S INFORMATION

NAME _____
First Name Last Name

SSN _____ BIRTHDAY ___ / ___ / ____
MM DD YYYY

ADDRESS _____
Street Name/Number

_____
City State Zip Code

EMPLOYER _____

◯ MARRIED ◯ DIVORCED

◯ SINGLE ◯ OTHER _____

DRIVER'S LICENSE # _____

HOME PHONE NUMBER (____) _____

WORK PHONE NUMBER (____) _____

CELL PHONE NUMBER (____) _____

EMAIL _____

HOW WOULD YOU PREFER APPOINTMENT REMINDERS?

◯ Text ◯ Phone Call _____
Home/Work/Cell?

FATHER'S INFORMATION

NAME _____
First Name Last Name

SSN _____ BIRTHDAY ___ / ___ / ____
MM DD YYYY

ADDRESS _____
Street Name/Number

_____
City State Zip Code

EMPLOYER _____

◯ MARRIED ◯ DIVORCED

◯ SINGLE ◯ OTHER _____

DRIVER'S LICENSE # _____

HOME PHONE NUMBER (____) _____

WORK PHONE NUMBER (____) _____

CELL PHONE NUMBER (____) _____

EMAIL _____

HOW WOULD YOU PREFER APPOINTMENT REMINDERS?

◯ Text ◯ Phone Call _____
Home/Work/Cell?

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Gehring, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

_____ _____
Signature of Parent/Guardian Date

*AT LEAST ONE PARENT'S SSN IS REQUIRED FOR BILLING PURPOSES. THANK YOU!