

# Aliso Kids Dental & Orthodontics

## New Patient Registration Form

We are complimented that you have selected us to provide dental care for your child!

**Whom may we thank for referring you?** \_\_\_\_\_

Last name:	_____	MI:	_____	First:	_____
Date of Birth:	_____	Age:	_____	Male	Female
Address:	_____				
City:	_____	State:	_____	Zip:	_____
Phone:	_____	Previous Dentist:	_____		
Reason for today's visit:	_____				
Date of last dental visit and x-rays:	_____	Allergies:	_____		

<b>Mother's</b> Name:	_____	Date of Birth:	_____		
Address (if different from above):	_____				
City:	_____	State:	_____	Zip:	_____
Phone:	_____	Cell:	_____	Email:	_____
Employer:	_____	Work Phone:	_____		
Occupation:	_____	Insurance:	_____		
Social Security:	_____	Drivers License:	_____		

<b>Father's</b> Name:	_____	Date of Birth:	_____		
Address (if different from above):	_____				
City:	_____	State:	_____	Zip:	_____
Phone:	_____	Cell:	_____	Email:	_____
Employer:	_____	Work Phone:	_____		
Occupation:	_____	Insurance:	_____		
Social Security:	_____	Drivers License:	_____		

<b>Primary Insurance:</b>	_____	Policy Holder:	_____		
ID or SS #:	_____	Group #:	_____		
Phone:	_____	Effective Date:	_____		
Referral or Authorization #:	_____	Referred By:	_____		
<b>Secondary Insurance:</b>	_____	Policy Holder:	_____		
ID or SS #:	_____	Group #:	_____		
Phone:	_____	Effective Date:	_____		