Varble Orthodontics, P.C.

Patient Registration - Child

Patient Name _____ Birthdate_____

Fathers Name _____

Name of Employer _____ Work Phone_____

Mothers Name _____

Name of Employer _____ Work Phone _____

Do mother, father and child live together? Yes ____ No____

If No., other address_____

Patient's Dentist Dr. _____

Who referred you to our office?_____

Insurance

Do you have orthodontic insurance? Yes ___ No ___ PPO_____

Insurance Name_____

Insurance Address _____

Subscriber Name_____ DOB _____ SSN _____

Policy/Group # _____ Ins Phone _____

I authorize release of any information relating to a claim. I understand that I am responsible for all costs of dental treatment.

_____ _____

Signed (Patient, or Parent if minor) Date

I hereby authorize payment of dental benefits, otherwise payable to me directly to Varble Orthodontics, P.C.

_____ _____

Signed (Insured Person) Date

HIPAA

I, _____, have received a c opy of this office's Notice of Privacy Policy.

_____ _____

(Parent Signature) Date