Rajneesh K. Dail, D.D.S.
Diplomate of the American Board of Pediatric Dentistry

Member of the

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Date___________________

PATIENT REGISTRATION FORM

-Children-

(1) Name____
(first) (last)

Nickname___________________________

Age______Birthdate____________ Boy Girl (please circle)

(2) Name____
(first) (last)

Nickname___________________________

Age______Birthdate____________ Boy Girl (please circle)

(3) Name____
(first) (last)

Nickname___________________________

Age______Birthdate____________ Boy Girl (please circle)

-Parent-

Name______________________

D.O.B.______________________

Occupation__________________

Employer___________________

Business Phone______________

City_______________________

-Parent-

Name______________________

D.O.B.______________________

Occupation__________________

Employer___________________

Business Phone______________

City_______________________

Home Address____
(city/zip)

Home Phone________________Cell Phone_________________ Emergency Contact___________________ Relation_______________

Email Address______________________________________ Address_________________________________ Phone____________

Do parents and Child all live together? Yes No If no, please explain____

*Whom may we thank for referring you to this office?*____

Separated parents: The parent/guardian present at the initial visit will be responsible for this account

I authorize routine dental procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and diagnostic radiographs considered necessary by the dentist for the comfort, health and well being of the child.

Parent or Legal Guardian (print)______________________________ SS#__________________(where appropriate, credit reports may be obtained)

Parent or Legal Guardian (signature)___________________________ Date_________________

INSURANCE INFORMATION

-Primary Coverage-

Subscriber Name____

Home Address____

City, State, Zip____

Social Security Number____________________________________

Name of Plan____

Employer____

Employer Address-Phone Number____________________________

Group Number____

Insurance Carrier____

Insurance Address_______________________________________

-Secondary Coverage (if applicable)-

Subscriber Name____

Home Address____

City, State, Zip____

Social Security Number____________________________________

Name of Plan____

Employer____

Employer Address-Phone Number____________________________

Group Number____

Insurance Carrier____

Insurance Address_______________________________________