Clayton Dental Office/River Pediatrics New Patient Registration

Patient Information:

Full Name:	Date of Birth:	Occupation:
Preferred Name:	Sex: __Male __Female	Employer:
Address:	Social Security #:	Driver's License #:
City, State, Zip:	Marital Status:	E-mail:
Cell Phone: ( )	Home Phone: ( )	Work Phone: ( )
Primary Care Physician Name/Location:	Primary Care Physician Phone Number: ( )	Preferred Pharmacy:

I would like to receive correspondence via e-mail **(Yes) (No)**, via text message **(Yes) (No) – Please Circle**

Parent/Guardian 1 Information: **(Please Circle)** Mother Father Step-Parent Foster Parent Legal Guardian Grandparent

Full Name:	Date of Birth:	Occupation:
Address:	Social Security #:	Employer:
City, State, Zip:	Marital Status:	E-mail:
Cell Phone: ( )	Home Phone: ( )	Work Phone: ( )

I would like to receive correspondence via e-mail **(Yes) (No)**, via text message **(Yes) (No) – Please Circle**

Parent/Guardian 2 Information: **(Please Circle)** Mother Father Step-Parent Foster Parent Legal Guardian Grandparent

Full Name:	Date of Birth:	Occupation:
Address:	Social Security #:	Employer:
City, State, Zip:	Marital Status:	E-mail:
Cell Phone: ( )	Home Phone: ( )	Work Phone: ( )

I would like to receive correspondence via e-mail **(Yes) (No)**, via text message **(Yes) (No) – Please Circle**

Child lives with **(please circle)**: Both parents(Together) Both Parents (Separately) Mother Father Grandparent Legal Guardian

Person Financially Responsible for the Patient's Dental Care: _____

Parent/Guardian Primary Contact Information – Phone Number: _____ E-mail: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

Do we have permission to use your child's name and picture in our monthly "No Cavity Club" and office contests (on-line - published on our office social media/website and in-office – displayed near front desk), if applicable? **(Yes) (No) – Please circle**

Primary Insurance Information:

Name of Insured:	ID Number:	Insurance Carrier:	Name of Insured:	ID Number:	Insurance Carrier:
Insured Social Security Number:	Insured Birth Date:	Relationship to Insured: **(Please Circle)** Self Spouse Child Other	Insured Social Security Number:	Insured Birth Date:	Relationship to Insured: **(Please Circle)** Self Spouse Child Other
Employer Name:	Employer Address:	Employer City, State, Zip:	Employer Name:	Employer Address:	Employer City, State, Zip:

Secondary Insurance Information: