MARGARET E. BARRY, D.D.S. - CROSSROADS PEDIATRIC DENTISTRY
REGISTRATION FORM

Patient's Name: _____ Birthday ____/____/____Age_____

Nickname/Preferred Name _____ Male ☐ Female ☐
Home Address_____
City _____ State _____ Zip _____
School _____Grade_____
Mother's Name _____ Father's Name_____
Guardian_____
Home Phone _____ Cellular Phone_____ Work Phone _____
Email_____
Parents are: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ☐ _____
How did you hear about our office? _____
Reason for visit _____

WE APPRECIATE YOUR TAKING THE TIME TO FILL OUT THIS FORM COMPLETELY

Insured Parent's Employer _____
Insured Parent's Employer Address_____
City _____ State _____
Mother's Driver License # _____Father's Driver's License#_____
Child's Social Security # _____
Mother's Social Security # _____ Father Social Security # _____
Person Responsible for Account (Other than Parent) _____

PRIMARY DENTAL INSURANCE	**SECONDARY DENTAL INSURANCE**
Insured's Name _____	Insured's Name _____
Date of Birth _____	Date of Birth_____
Employer _____	Employer _____
Insurance Co. _____	Insurance Co._____
Policy No._____ Effective Date _____	Policy No. _____ Effective Date_____

WE BILL MOST MAJOR INSURANCE COMPANIES ON YOUR BEHALF.	WE ACCEPT PAYMENT BY MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER .

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered completely and fully to my knowledge and satisfaction. I acknowledge that any errors or omissions that I have made in the completion of this form may affect my child's dental care, and I will do my best to correct these errors as soon as I become aware of them. I hereby authorize payment of insurance dental benefits otherwise payable to me, to Margaret E. Barry, D.D.S. T/A Crossroads Pediatric Dentistry. I realize that I am responsible for any charges not covered by this authorization.

Signature _____ Date _____