Registration – Minor

Patient Information:

First Name: _____MI: _____ Last Name: _____Preferred: _____

Address: _____ City: _____State: _____Zip: _____

Date of Birth: _____ SS #: _____ Sex: ◯ Female ◯ Male

Parent/Guardian's Names: _____ Alt. Address (if any): _____

E-Mail Address: _____ ◯ I would like to receive correspondences via e-mail.

Check preferred contact number:

◯ Home: _____ ◯ Work: _____Ext:_____ ◯ Cell:_____

Student Status: ◯ Full Time ◯ Part Time School Name: _____ City & State: _____

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

◯ **Not Covered by Dental Insurance – Self Pay**

Insurance Information: (If patient is the insurance policy holder, duplicate information fields may be skipped)

Primary Dental Insurance Company: _____ Subscriber's Employer: _____

Subscriber of Insurance: _____ DOB of Subscriber: _____ Relationship to Patient: _____

Subscriber SS #: _____ Alternate ID #: _____ Group #: _____

Secondary Dental Insurance Company: _____ Subscriber's Employer: _____

Subscriber of Insurance: _____ DOB of Subscriber: _____ Relationship to Patient: _____

Subscriber SS #: _____ Alternate ID #: _____ Group #: _____

Referrals: We would love to know how you were referred to us: ◯ Insurance Company/Website ◯ Phonebook ◯ Mailer/Postcard ◯ Driving By/Window ◯ Patient or Provider:_____

Acknowledgements:

Minor / Child Consent: I am the parent / guardian of _____, and there are no court orders in effect that prohibit me from signing this consent. I hereby request and authorize Dr. Joseph W. Costa. Jr., DMD to perform necessary dental services for the above named child including but not limited to diagnostic and/or preventative procedures, updating X-rays, administering anesthetics, and other treatment mutually agreed upon by me and as deemed advisable by the dentist. I hereby authorize Dr. Joseph W. Costa. Jr., DMD to proceed with such dental services whether or not I am present at the time treatment is rendered.

Insurance Assignment / Release: I certify that the above named patient is covered as my dependent by insurance as specified and assign Dr. Joseph W. Costa. Jr., DMD all insurance benefits, if any, otherwise payable to me for services rendered. Dr. Joseph W. Costa. Jr., DMD may use and disclose health information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Receipt of Notice of Privacy Practices: I certify that I have been provided a copy of this office's Notice of Privacy Practices. (Separate Printout)

I,_____, have provided accurate information to the best of my ability.

Print Parent/Guardian Name

_____ _____

Signature of Parent/Guardian **Date**