

FAMILY REGISTRATION

Responsible Party Information

Child's Father's / Guardian's Full Name	
Relationship to Patient	Spouse's Name
Address	
City	State ZIP
How long at this address?	Home Phone Number
Previous address (If less than 3 years)	
Social Security Number	Date of Birth Marital status
Employer	Occupation
No. Years Employed	Work Phone number (with extension)
E-Mail	Fax / Cell Phone / Pager

Child's Mother's / Guardian's Full Name	
Relationship to Patient	Spouse's Name
Address	
City	State ZIP
How long at this address?	Home Phone Number
Previous address (If less than 3 years)	
Social Security Number	Date of Birth Marital status
Employer	Occupation
No. Years Employed	Work Phone number (with extension)
E-Mail	Fax / Cell Phone / Pager

Who may we thank for referring you?

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Emergency Information

Name of nearest relative not living with you
Relationship to Patient
Address
City State ZIP Phone

Dental Insurance

Insured's Name
Insurance Company
Insurance Company Address
Group Number

Signature on File: I authorize that payment of dental benefits be made to Dr. Dennis Campbell on any claims submitted for services furnished me by Dr. Campbell and his team. I agree that this authorization shall be valid until recinded.

Signed _____

Your Children

Name	Sex	Birth Date

I understand that the confidential information requested above is necessary to provide my children with dental care in an efficient manner. I understand that, where appropriate, credit bureau reports may be obtained. I have completed this page accurately to the best of my knowledge.

Signature (Parent or Guardian) _____

Today's Date: _____ Updates: _____