Suncook Dental

Child Patient Registration

Please read, complete and sign all portions of this Registration Form for your child. The information you provide on this form is confidential and will NOT be released to anyone without your prior written consent. Thank you.

Child's Full Name ____
Child's Address ____
City _______________________ State ____________ ZIP ________________
Date of Birth ___________ Circle One: Male Female S.S.N ________________
Responsible Adult(s) ____
Responsible Adult(s) Contacts: Cell Phone _________ Home Phone ________Work Phone_______
Responsible Adult's Employer ____
Responsible Adult's Email _____________________

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Who is responsible for this account? ____
How will you settle this account? Cash Check Credit/Debit Card

For new patients, how were you referred to our office? Please circle.

Sign Phonebook Website Patient___________________

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Primary Insured's Full Name _________________________Primary Insureds S.S.N.____________
Primary Insured's Date of Birth____________________
Primary Insured's Employer ____
Primary Insured's Insurance Company _________________________Group Number ___________

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Secondary Insured's Full Name ______________________ Secondary Insured's S.S.N __________
Secondary Insured's Date of Birth __________________
Secondary Insured's Employer ____
Secondary Insured's Insurance Co ____________________________ Group Number ___________

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As a courtesy and convenience to you, our office will submit charges for dental services to your insurance carrier. However, the parent or guardian is primarily responsible for the financial charges, in other words, the services provided by any dentist or hygienist amounts to an agreement between the patient and this office. The insurance relationship constitutes an agreement between the carrier and the insured.

Please remember that insurance benefits are determined by the type of plan chosen by the employer. We urge you to read your policy so you are fully aware of any limitations of the benefits provided. Of course, we will do whatever we can to see that you receive maximum benefits within the structure of your particular group dental plan.

If there are any questions regarding your account, please call. Many times a phone call will prevent a misunderstanding.

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Patient Insurance Consent

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to Suncook Dental. This form also authorizes Suncook Dental to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "Signature on File". I authorize Suncook Dental to release treatment or any information deemed pertinent to my insurance carrier as necessary and / or requested.

Parent or Guardian Signature____ Date______________