DONOHUE & DONOHUE D.D.S., PC

Terry J. Donohue DDS, Timothy M. Donohue DDS, Kelly M. Donohue DDS
323 West Maple Street, P.O. Box 848 Carson City, MI 48811
989-584-3171 Office 989-584-3013 Fax

CHILD PATIENT REGISTRATION FORM

Your Child's Information

First Name:_____ **Last Name:** _____ **Middle:**_____ **Male / Female**

Date of birth:_____ **Preferred Name:**_____

Responsible Parent or Guardian Information

Name:_____ Soc. Sec. #: _____
(First) (MI) (Last)

Drivers Lic #: _____ Sex: Male / Female Date of Birth: _____ Age: _____

Address: _____
(Street) (P.O. Box) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: Married Single Divorced Widowed Separated Maiden Name: _____E-Mail Address_____

Preferred Method of Contact (please circle best options) **Cell Home Work Email Text**
May we contact you at work if needed? Y N
May we send email/text correspondence regarding appointments? Y N

Occupation: _____Employer:_____

In the event of an emergency, whom should we contact? Name:_____
Phone: _____ Address:_____

Person responsible for bill _____

Insurance Information:

Name of Primary Insured: _____ Insured's Date of Birth: _____

Insured's Soc. Sec. #: _____ Relationship to Patient: _____

Insured's Employer: _____ Employer Phone: _____

Insurance Co. Name: _____ Policy #: _____ Group #_____

Name of Secondary Insured: _____ Insured's Date of Birth: _____

Sec. Insured's Soc. Sec. #: _____ Relationship to Patient: _____

Sec. Insured's Employer: _____ Employer Phone: _____

Sec. Insurance Co. Name: _____ Policy #_____ Group #_____

Authorization and Release

I authorize the dentist and staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent.
I authorize the dentist and staff to release any information including diagnosis and records of any treatment or examination rendered to third party payers and/or other health practitioners. I authorize and request my dental benefits company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to myself, or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. A copy of our financial policy is available upon request.

_____ _____
Signature of Patient or Parent/Guardian if a Minor Today's Date