Child Registration Form

Thompson Orthodontics
1450 Columbus Avenue, Suite 101
Washington Court House, OH 43160
740.335.2921

Today's Date: _____

Child's Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Preferred Name: _____ Age: _____ Gender: (circle one) Male Female

Child's Address: _____
(Street) (City) (State) (Zip)

Child's Home Phone: _____ Child's Cell Phone: _____

Name of School: _____ Expected year of graduation: _____

Indicate quality of patient's school work: A student B student C student D student

Music lessons: Yes No Which instrument: _____

Sports: Yes No Which sports: _____

Hobbies: _____

Responsible Party #1: Social Security No. _____

Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Preferred Phone #: _____ Other Phone #: _____

Email: _____ Relationship to Child: _____

Employed By: _____ Occupation: _____

Responsible Party #2: Social Security No. _____

Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Preferred Phone #: _____ Cell Phone #: _____

Email: _____ Relationship to Child: _____

Employed By: _____ Occupation: _____

Dental insurance? Yes No Who holds insurance policy? _____
If yes, what insurance company? _____ Group No. _____

Signature below authorizes release of information to my insurance company & payment to be sent directly to orthodontist
By signing this form you assume financial responsibility for the fees for care at Thompson Orthodontics

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____