Alameda Pediatric Dentistry & Orthodontics

Alameda (510) 521-5437 • Pleasanton (925) 846-5437 • Oakland (510) 763-5437 • Brentwood (925) 516-4107

PATIENT REGISTRATION

Please fill out this form in its entirety.

Parent/Guardian Responsible for Account

Name ____

Pronouns __________ Relationship to patient _________

Date of Birth (MM/DD/YYYY) ______ / ______ / _______

Cell (_____) ____________Work (_____) ____________

Email ____

Address _______________________________________

City ___________________________ Zip ____________

Occupation/Position ______________________________

Second Parent/Guardian

Name ____

Pronouns __________ Relationship to patient _________

Date of Birth (MM/DD/YYYY) ______ / ______ / _______

Cell (_____) ____________Work (_____) ____________

Email ____

Address (if different) ______________________________

City ___________________________ Zip ____________

Occupation/Position ______________________________

Parent/Guardian Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Child resides with: ___________________________

DENTAL INSURANCE INFORMATION

Does your child have state funded insurance (ex: Medi-Cal/Denti-Cal/Alameda Health Alliance)? ☐ Yes ☐ No

Primary Insurance Policy Holder Name ___________________________ Employer ______________________________

Dental Insurance Company ______________________________ Member/Enrollee ID# ____________________

Policy Holder DOB ____________________________ Policy Holder SSN ______________________________

Secondary Insurance Policy Holder Name (if applicable) ____________________ Employer ____________________

Dental Insurance Company ______________________________ Member/Enrollee ID# ____________________

Policy Holder DOB ____________________________ Policy Holder SSN ______________________________

PATIENT INFORMATION

Name ____ Preferred Name __________________

Date of Birth (MM/DD/YYYY) _______ / _______ / _________ Age ____________

☐ Male ☐ Female | Preferred Pronouns _____________________ Gender Identity _______________________________

School Name ___________________________________ Favorites ____

Sports and/or Hobbies ________________________________ Musical Instruments Played ________________________

Has your child been seen by a previous dentist? If yes, Dentist Name: ____________________________________

Date of last visit: __________________ Phone #: (_____) ____________ Any Notes: __________________

How did you hear about our office? ____

Has any member of your family been a patient of this office before? ☐ Yes ☐ No | Name(s) ________________________

I authorize examination and routine dental procedures for my child. I am aware that the dental office will submit insurance claims as a courtesy and attempt to collect from the insurance company. However, I am ultimately responsible to know my benefits, and assume full responsibility for any outstanding account balance.
I am aware that cancellation fees may apply for missed or cancelled appointments within 48 hours.
I consent to receiving text messages, emails, and phone calls from the dental office.

Parent/Guardian Signature ____ Date ______________________