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 _____