Dental Associates of Baraboo ◊ 880 14th Street ◊ Baraboo, WI 53913 ◊ 608-356-6611

Please use [TAB] key or MOUSE to navigate through the Form.

PATIENT REGISTRATION
CHILD

Dental Associates of Baraboo requires a parent's Social Security number in order to submit this form electronically.

PATIENT INFORMATION (If patient is a dependent, please complete Parent/Guardian sections also)

Last Name: _____ First: _____ MI: ___ Sex: Male ◯ Female ◯

Date of Birth: _____ *(mm/dd/yy)* Social Sec. #: _____ *(xxx-xx-xxxx)*

Home Address: _____ City/State: _____ Zip: _____

Home Phone: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

PARENT/GUARDIAN (#1) INFORMATION (complete ONLY IF Patient is YOUR dependent)

Parent ◯ Step-Parent ◯ Legal Guardian ◯

Last Name: _____ First: _____ MI: ___ Sex: Male ◯ Female ◯

Date of Birth: _____ *(mm/dd/yy)* Social Sec. # _____ *(xxx-xx-xxxx)*

Home Address: _____ City/State: _____ Zip: _____

Phone Home: _____ Cell: _____ Email: _____

Employer: _____ Occupation: _____

Business Phone: _____

PARENT/GUARDIAN (#2) INFORMATION (complete ONLY IF Patient is YOUR dependent)

Parent ◯ Step-Parent ◯ Legal Guardian ◯

Last Name: _____ First: _____ MI: ___ Sex: Male ◯ Female ◯

Date of Birth: _____ *(mm/dd/yy)* Social Sec. #: _____ *(xxx-xx-xxxx)*

Home Address: _____ City/State: _____Zip: _____

Phone Home: _____ Cell: _____Email: _____

Employer: _____ Occupation: _____

Business Phone: _____

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DENTAL INSURANCE INFORMATION

Primary Dental Insurance: Yes ○ No ○

If Yes, Policy Holder Name: _____ Date of Birth: _____ *(mm/dd/yy)*

Holder's Social Security#: _____*(xxx-xx-xxxx)*Type of Coverage: Individual ○ Family ○

Insurance Company Name: _____

Insurance Co. Address: _____

Group #: _____ Policy/Sub #: _____

Secondary Dental Insurance: Yes ○ No ○

If Yes, Policy Holder Name: _____ Date of Birth: _____ (mm/dd/yy)

Holder's Social Security#: _____*(xxx-xx-xxxx)*Type of Coverage: Individual ○ Family ○

Insurance Company Name: _____

Insurance Co. Address: _____

Group #: _____ Policy/Sub #: _____

Tertiary(3rd) Dental Insurance: Yes ○ No ○

If Yes, Policy Holder Name: _____ Date of Birth: _____ (mm/dd/yy)

Holder's Social Security#: _____*(xxx-xx-xxxx)*Type of Coverage: Individual ○ Family ○

Insurance Company Name: _____

Insurance Co. Address: _____

Group #: _____ Policy/Sub #: _____

How would you prefer to be notified of appointments and other information?

Home Phone ☐ Work Phone ☐ Email ☐ _____

Cell Phone ☐ Text Message ☐ (Please select additional preferred method)

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to *Dental Associates of Baraboo*, of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

_____ _____

Parent or Guardian Signature Date

Please note: Dental Associates of Baraboo will not share your information with outside sources