Friendly Smiles
Family Dentistry

Child New Patient Registration

Name of Child_____ Nickname _____

Sex: male female Birth Date _____ Hobbies _____

Social Security # _____

Address _____

City_____ State, Zip Code _____

Phone: Home _____ Parent's Work _____

Parent's Cell _____ Email _____

Pharmacy _____ Pharmacy Phone _____

Pediatrician _____ Pediatrician Phone _____

Former Dentist _____ City/State _____

Date of Last Dental Visit _____ Last Dental X-rays _____

How did you hear about us? Please check all that apply

office sign _ health care professional _ website _ google _ facebook _ NJ magazine _

playbill _ church bulletin _ yearbook _ ball field banner _ St. Margaret School _

If a friend or family referred you, who may we thank? _____

Primary Insurance Information

Name of Insured _____ Relation to Patient _____

Birth Date _____ Social Security # _____

Address (if different from patient) _____

City, State, Zip Code _____ _

Employer _____

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