Family Dentistry of Mukilteo
833 2nd Street Suite A.
Mukilteo, WA 98275

Child Patient Registration (Under age 18)

Today's Date

Patient First M. Last

DOB SS#

Mother or Guardian Information

First M. Last

Address

Cell# Home#

Work DOB SS#

Marital Status Email

Father or Guardian Information

First M. Last

Address

Cell# Home#

Work DOB SS#

Marital Status Email

Who may we thank for referring your son or daughter?

Primary Dental Insurance

Company ID#

Subscriber DOB Sub Relationship to Patient

Sub SS# Grp#

Sub Address

Secondary Dental Insurance

Company ID#

Subscriber DOB Sub Relationship to Patient

Sub SS# Grp#

Sub Address

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information. Family Dentistry of Mukilteo reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If they change I will be offered a copy of the revision and may request that it be mailed to me.

I herby specifically authorize disclosure of my son and or daughters protected health care information to the persons indicated: _____

I have filled in my information to the best of my ability and understand that it will be used to bill my dental insurance and to acknowledge receipt of the Notice of Privacy Practices.

Parent/Guardian Signature:_____ **Printed Name:**_____