



REGISTRATION

DR. H. GRACE YEH
 PEDIATRIC DENTISTRY
 1148 S. GARFIELD AVE.
 ALHAMBRA, CA 91801
 ☎ (626) 300-1199

DATE				1
NAME				
ADDRESS				
CITY	STATE	ZIP		
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				



DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
SOCIAL SECURITY #		
D.L. #		
<input type="checkbox"/> MOTHER <input type="checkbox"/> GUARDIAN		
NAME		
OCCUPATION		
EMPLOYER		
CELL. PHONE NO.		
BUSINESS PHONE NO.		EXT.
<input type="checkbox"/> FATHER <input type="checkbox"/> GUARDIAN		
NAME		
OCCUPATION		
EMPLOYER		
CELL. PHONE NO.		
BUSINESS PHONE NO.		EXT.



GETTING TO KNOW YOUR CHILD		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP



CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the used of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of and possible complications.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any change in the information contained on this form.
6. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due of the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Parent / Guardian Signature _____ Date _____ Witness _____

