CHERYL M. LEE, DDS, MS

PEDIATRIC & ADOLESCENT DENTISTRY

1174 CASTRO STREET, SUITE 150, MOUNTAIN VIEW, CA 94040 TELEPHONE (650) 965-8688 FAX (650) 965-7988

NEW PATIENT REGISTRATION FORM

GENERAL INFORMATION

This information is requested for financial and credit purpose.

Child's Name_____Date of Birth _____

Name of person who is financially responsible for the child _____

MOTHER (full name)_____Date of Birth_____ Occupation _____

Home address_____City/State/Zip _____

Home phone_____ Work phone _____ Cell phone _____

Employer_____Address_____City/State/Zip_____Phone _____

Social security number _____

FATHER (full name)_____Date of Birth_____ Occupation _____

Home address_____City/State/Zip _____

Home phone_____ Work phone _____ Cell phone _____

Employer_____Address_____City/State/Zip_____Phone _____

Social security number _____

Child resides with: Both parents_____ Mother_____ Father _____ Other_____ (Please specify)

Person to contact in case of emergency: Name_____ Relationship to child _____

Address_____City_____Home phone_____ Work phone_____

INSURANCE INFORMATION

Do you have dental insurance? ____Yes ____No

MOTHER: Name of Insurance Company_____ Group/Policy No. _____

Address_____ Phone_____

FATHER: Name of Insurance Company_____ Group/Policy No. _____

Address_____ Phone_____

Please send this form back to our office by mail or fax (650) 965-7988 before the appointment day.

We greatly appreciate your assistance.