Southern Kentucky Smiles
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Bowling Green, KY 42101
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CHILD REGISTRATION FORM

Name _____ Birthdate _____ ☐ Male ☐ Female SSN#: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ School _____ Grade _____

Person Responsible for Account _____

Relationship to Child _____

Child Resides with: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Name of Mother/Guardian _____ Birthdate _____

SS# _____ Home / Cell _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Name of Father/Guardian _____ Birthdate _____

SS# _____ Home / Cell _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

CHILD'S DENTAL HISTORY

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty Clicking and/or Pain

CHILD'S HEALTH HISTORY

Please check all that apply to your child: _____

☐ Allergies	☐ Epilepsy	☐ Scarlet Fever	☐ Asthma
☐ Anemia	☐ HIV/AIDS	☐ Tonsillitis	☐ Heart Murmur
☐ Tuberculosis	☐ Cancer	☐ Hepatitis-Type	☐ Diabetes
☐ Rheumatic Fever	☐ Other:		

PRIMARY DENTAL INSURANCE

Employer _____ Work Phone _____

Employer Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Insured Date of Birth _____

ADDITIONAL INSURANCE

Employer _____ Work Phone _____

Employer Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Insured Date of Birth _____

ADDITIONAL INSURANCE

I hereby authorize payment directly to Southern Kentucky Smiles / Dr. Casey Travelsted for all insurance benefits otherwise payable to me for services rendered. I'll understand that I am financially responsible for all changes, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____