

**GARTNER ORTHODONTICS, LTD.  
REGISTRATION FORM – MINOR**

Patient's Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Parents: Married ( ) Divorced ( ) Separated ( ) Widowed ( )

Father \_\_\_\_\_ Mother \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Wk# \_\_\_\_\_ Cell # \_\_\_\_\_ Wk# \_\_\_\_\_ Cell # \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

If divorced, address of responsible party \_\_\_\_\_

If divorced, who does child live with? \_\_\_\_\_

Who may we thank for this referral? \_\_\_\_\_

Someone to notify in case of emergency? \_\_\_\_\_

Telephone # \_\_\_\_\_ Relationship \_\_\_\_\_

Primary DENTAL Ins. Coverage

Secondary DENTAL Ins. Coverage

Name \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Ins. Co. \_\_\_\_\_

Ins. Co. \_\_\_\_\_

**IN ORDER FOR OUR OFFICE TO SUBMIT ANY INSURANCE, WE NEED TO  
HAVE A FRONT & BACK COPY OF YOUR DENTAL INSURANCE CARD**

**RELEASE:**

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for dental care ( ). I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits ( ). I understand that I am responsible for all costs of treatment ( ).

I attest to the accuracy of the information on this page.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_