

**HAROLD S. MARKS D.D.S. P.A. - CROSSROADS PEDIATRIC
DENTISTRY
REGISTRATION FORM**

Patient's Name: _____ Birthday ____/____/____ Age _____

Home Address _____

City _____ State _____ Zip _____

Name and Address of School _____

Mother's Name _____ Father's Name _____

Guardian _____

Home Phone _____ Cellular Phone _____ Work Phone _____

Parent's are: Single Married Separated Divorced Widowed Other _____

How did you hear about our office? _____

Reason for visit _____

Parent's Email Address: _____

WE APPRECIATE YOUR TAKING THE TIME TO FILL OUT THIS FORM COMPLETELY

Insured Parent's Employer _____

Insured Parent's Employer Address _____

City _____ State _____

Mother's Driver License # _____ Father's Driver's
License# _____

Child's Social Security # _____

Mother's Social Security # _____ Father Social Security # _____

Person Responsible for Account (Other than Parent) _____

PRIMARY DENTAL INSURANCE

Insured's Name _____

Date of Birth _____

Employer + Insurance Co. _____

_____ Policy No. _____

Effective Date _____

SECONDARY DENTAL INSURANCE

Insured's Name _____

Date of Birth _____

Employer + Insurance Co. _____

_____ Policy No. _____

Effective Date _____

**WE BILL MOST MAJOR INSURANCE
COMPANIES ON YOUR BEHALF.**

**WE ACCEPT PAYMENT BY MASTERCARD,
VISA, AMERICAN EXPRESS, DISCOVER .**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered completely and fully to my knowledge and satisfaction. I acknowledge that any errors or omissions that I have made in the completion of this form may affect my child's dental care, and I will do my best to correct these errors as soon as I become aware of them. I hereby authorize payment of insurance dental benefits otherwise payable to me, to Harold S. Marks D.D.S., P.A. T/A Crossroads Pediatric Dentistry. I realize that I am responsible for any charges not covered by this authorization.

Signature _____ Date _____