Brick Pediatric Dentistry
& Orthodontics, P.C.
Seymour Semah, D.M.D.
Diplomate American Board of Pediatric Dentistry

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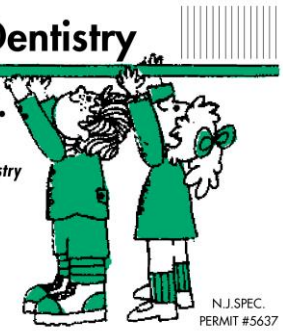

N.J.SPEC.
PERMIT #5637

PATIENT REGISTRATION FORM

Date: _____

Account Number: _____

PATIENT INFORMATION – PLEASE PRINT CLEARLY

PATIENT'S NAME _____ DATE OF BIRTH _____
NICKNAME _____ AGE _____ GENDER ___ HOME PHONE # _____
HOME ADDRESS _____ CITY _____ ZIP _____
CHILD LIVES WITH: BOTH PARENTS ___ MOTHER ___ FATHER ___ OTHER_____
PARENTS ARE: MARRIED __ SEPARATED __ DIVORCED __ NEVER MARRIED _____
OTHER CHILDREN _____ IN PRACTICE _____
HOBBIES _____ SCHOOL _____ GRADE _____

PARENT / GUARDIAN INFORMATION – PLEASE PRINT CLEARLY

FATHER'S NAME _____ DATE OF BIRTH _____
HOME ADDRESS _____ CITY _____ ZIP _____
EMPLOYED BY _____ HOW LONG _____ JOB TITLE _____ DEPT_____
BUSINESS ADDRESS _____ CITY _____ E-MAIL _____
HOME PHONE # _____ BUSINESS PHONE # _____ CELL # _____
SOCIAL SECURITY # (*required*) _____ DRIVER'S LICENSE # _____

MOTHER'S NAME _____ DATE OF BIRTH _____
HOME ADDRESS _____ CITY _____ ZIP _____
EMPLOYED BY _____ HOW LONG _____ JOB TITLE _____ DEPT_____
BUSINESS ADDRESS _____ CITY _____ E-MAIL _____
HOME PHONE # _____ BUSINESS PHONE # _____ CELL # _____
SOCIAL SECURITY # (*required*) _____ DRIVER'S LICENSE # _____

STEP-PARENT/GUARDIAN _____ RELATIONSHIP _____ DOB _____
HOME ADDRESS _____ CITY _____ ZIP _____
EMPLOYED BY _____ HOW LONG _____ JOB TITLE _____ DEPT_____
HOME PHONE # _____ CELL # _____ E-MAIL _____
SOCIAL SECURITY # (*required*) _____ DRIVER'S LICENSE # _____

DENTAL INSURANCE INFORMATION – PLEASE PRINT CLEARLY

FATHER'S INSURANCE _____ GROUP # _____
MOTHER'S INSURANCE _____ GROUP # _____
STEP-PARENT/GUARDIAN INSURANCE _____ GROUP # _____

OTHER INFORMATION – PLEASE PRINT CLEARLY

EMERGENCY CONTACT NAME _____ EMERGENCY NUMBER _____
RELATIONSHIP TO PATIENT _____
WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____
I WILL BE PAYING BY CASH _____ CHECK _____ CREDIT CARD _____
MAIN REASON FOR VISIT_____ _____

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. A LATE FEE OF 1.5% MONTHLY WILL APPLY ON OVERDUE ACCOUNTS. I WILL BE RESPONSIBLE FOR ANY COSTS INCURRED BY THIS OFFICE TO COLLECT OVERDUE ACCOUNTS, INCLUDING ANY COURT FEES AND A 50% COLLECTION FEE. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PRINT NAME _____ SIGNATURE _____ DATE _____