REGISTRATION

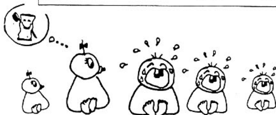
DR. H. GRACE YEH
PEDIATRIC DENTISTRY
1148 S. GARFIELD AVE.
ALHAMBRA, CA 91801
☎ (626) 300-1199

DATE	1
NAME	
ADDRESS	
CITY STATE ZIP	
HOME PHONE NO.	
BIRTHDATE AGE MALE FEMALE	
SCHOOL GRADE	
SOCIAL SECURITY NO.	

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

GETTING TO KNOW YOUR CHILD	3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	**RELATIONSHIP:**
REFERRED TO US BY	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY STATE ZIP	
CLOSEST RELATIVE NOT LIVING WITY YOU	
PHONE NUMBER	
ADDRESS	
CITY STATE ZIP	

ACCOUNT INFORMATION	4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY STATE ZIP	
PHONE NO.	
SOCIAL SECURITY #	
D.L #	
☐MOTHER	☐GUARDIAN
NAME	
OCCUPATION	
EMPLOYER	
CELL PHONE NO.	
BUSINESS PHONE NO.	EXT.
☐FATHER	☐GUARDIAN
NAME	
OCCPUPATION	
EMPLOYER	
CELL PHONE NO	
BUSINESS PHONE NO.	EXT.



CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to empoly such assistance as required to provide proper care.

3. I agree to the used of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of and possible complications.

4. I understand that where appropriate, credit bureau reports many be obtained.

5. I understand that it is my responsibility to advise your office of any change in the information contained on this form.

6. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due of the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Parent / Guardian Signature________________________Date_____________Witness____________