STURZ & ABBY PEDIATRIC DENTISTRY

PATIENT REGISTRATION FORM

STURZ Abby

PATIENT INFORMATION		
Child's Name (Last, First, Middle)	Nickname	
Address	Home Phone	
City	State	Zip
Date of Birth	Age	Patient's Sex:
Emergency Contact person name & phone number:		

MOTHER/GUARDIAN INFORMATION		
Name (Last, First)		
Social Security #	Date of Birth	
Address (if different than patient's)		
City	State	Zip
Home Phone	Cell Phone	
Occupation		
Employer	Business Phone	

FATHER/GUARDIAN INFORMATION		
Name (Last, First)		
Social Security #	Date of Birth	
Address (if different than patient's)		
City	State	Zip
Home Phone	Cell Phone	
Occupation		
Employer	Business Phone	

I request and authorize Dr. Sturz, Dr. Abby & Associates to examine and provide dental treatment to my child. This includes the taking of dental radiographs as deemed necessary by the dentist to diagnose and/or treat my child's dental condition. I authorize the release of information regarding the diagnosis and treatment of my child's dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the acutal bill for services. I agree to be responsible for payment of all services rendered on my child's behalf. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Sturz, Dr. Abby & Associates will provide an enviroment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Additionally, I authorize phone, text, and/or email communication with the agents of Sturz & Abby Dental, Inc. regarding my child's account, appointments and/or oral health.

Printed Name of Parent/Guardian _____ **Date:** _____

Signature of Parent/Guardian _____ **Date:** _____

I have received a copy of the Dental Materials Fact Sheet and Notice of Privacy Practices as required by law.

Signature of Parent/Guardian _____ **Date:** _____