BOTHELL PEDIATRIC DENTISTRY

SPECIALISTS IN INFANTS, CHILDREN & ADOLESCENTS

FAMILY REGISTRATION

Billing Information: Name _____

Address _____

Street City State Zip

Prefer Contact by: Phone # _____ Text Message #_____

Email _____

Parent Name _____ Step-parent/Guardian Birth Date ____/_____/_____

Address (if different than above) _____

Street City State Zip

Hm □ Wk □ Cell □_____ Hm □ Wk □ Cell □_____ Email_____

Parent Name _____ Step-parent/Guardian Birth Date ____/_____/_____

Address (if different than above) _____

Street City State Zip

Hm □ Wk □ Cell □_____ Hm □ Wk □ Cell □_____ Email_____

Dental Insurance Information

Primary Coverage: Subscriber Name _____ S.S.#/ID#_____

Name of Employer _____ Group # _____

Insurance Co. _____Insurance Co. Phone _____

Insurance Co. Address _____

Secondary Coverage: Subscriber Name _____S.S.#/ID#_____

Name of Employer _____ Group # _____

Insurance Co. _____Insurance Co. Phone _____

Insurance Co. Address _____

If parents can't be reached, friend or relative to notify should an emergency arise:

Name _____ Relation _____ Phone _____

If new to this area, let us know if you would like a referral to a pediatrician for your child or a dentist for adult care.

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I authorize Dr. Yea, McCoy & Dallman and their staff to use any anesthetics or pre-medication considered medically necessary or advisable for the comfort and well being of my child.

I understand that I am financially responsible to Yoo-Lee Yea DDS PLLC for any charges not payable by dental insurance.

Parent/Guardian Signature _____Date_____