Welcome to Specialty Dental Café…
We cater to your needs!

New Patient Registration Form

We are complimented that you have selected us to provide dental care for your child. Whom may we thank for referring you?

Patient Information

Last Name: ________________________________ MI ________ First:__________________________

Date of Birth: ________________________ Age: ____________________ Male Female

Address: ____

City: _________________________________ State: ____________ Zip: ________________________

Phone: _____________________________ e-mail: ____

Preferred Name or Nick Name: ____

Mother's Name: _______________________________________ Date of Birth:___________________
Address: (if different from above) ____
City: ______________________________ State: ____________ Zip: __________________________

Home Phone: ___________________ Cell: ___________________ e-mail: ____________________
Employer: ____ Work Phone: __________________

Social Security: ______________________________ Drivers License: _________________________

Father's Name: _______________________________________ Date of Birth: ___________________
Address: (if different from above) ____
City: ______________________________ State: ____________ Zip: ______________________________

Home Phone: __________________ Cell: ____________________ e-mail: _______________________
Employer: ____ Work Phone: ____________________

Social Security: ______________________________ Drivers License: __________________________

Insurance: _______________________________________ Policy Holder: _________________________
ID Number: ___________________________________ Group Number: ________________________
Relationship to child: ____
Other Insurance? ____