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Family and Child's Registration

Today's Date _____

Father or Guardian:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Social Security #: _____

Driver's License #: _____

Date of Birth: _____

Employer: _____

Mother or Guardian:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Social Security #: _____

Driver's License #: _____

Date of Birth: _____

Employer: _____

Your Child's/ Children's Name (s):

_____ M__F__ Age: _____ Birthdate: _____

_____ M__F__ Age: _____ Birthdate: _____

_____ M__F__ Age: _____ Birthdate: _____

_____ M__F__ Age: _____ Birthdate: _____

Dental Insurance Carrier:

Secondary Dental Insurance Carrier:

Primary Insurance Policy Holder:

Secondary Insurance Policy Holder:

Group #: _____

Group #: _____

ID#: _____

ID#: _____

Phone Number: _____

Phone Number: _____

Whom may we thank for referring you to our office? _____