

FAMILY ORTHODONTIC CARE, P.C.

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**CHILD REGISTRATION FORM
(PLEASE PRINT & BRING WITH YOU TO APPOINTMENT)**

Date: ___/___/___

Patient Name - Last _____ First _____ MI _____

Nickname _____ DOB ___/___/___ Age _____ Sex _____

Patient Address _____

Home Phone No. _____ Emergency Contact _____ Phone _____

Mother's Name _____ DOB ___/___/___ S.S.# _____

Address (if different than patient) _____

Home Phone _____ Bus. Phone _____ Cell Phone _____

Employer _____ Can we call you at work? Yes / No

Employer Address _____

Father's Name _____ DOB ___/___/___ S.S.# _____

Address (if different than patient) _____

Home Phone _____ Bus. Phone _____ Cell Phone _____

Employer _____ Can we call you at work? Yes / No

Employer Address _____

INSURANCE

PRIMARY INSURANCE

Name of Insurance Company _____ Orthodontic Max: \$ _____

Insurance Address _____

Subscriber's Name _____ DOB ___/___/___ Relationship to Patient _____

S.S. # _____ ID# _____ GROUP# _____

Employer Name & Address _____

SECONDARY INSURANCE

Name of Insurance Company _____ Orthodontic Max: \$ _____

Insurance Address _____

Subscriber's Name _____ DOB ___/___/___ Relationship to Patient _____

S.S. # _____ ID# _____ GROUP# _____

Employer Name & Address _____

OVER

AUTHORIZATIONS

I authorize Family Orthodontic Care, PC to release my protected health information to my dental benefit plan needed to carry out payment activities in connection with dental services rendered. I also agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

X _____
Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Family Orthodontic Care, P.C.

X _____
Subscriber Signature Date

Family Orthodontic Care may call my business phone to reach me during the day to discuss treatment, scheduling, or account issues regarding myself / my child.

X _____
Patient/Guardian Signature Date

ACKNOWLEDGEMENT

I hereby acknowledge that I have received a copy of Family Orthodontic Care's **Notice of Privacy Practices**. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient Name: _____ Parent/Guardian Name _____
(Please Print) If under 18 (Please Print)

Signature _____ Date _____
(Parent/Guardian if under 18)

Relationship to Patient _____