

**PATIENT REGISTRATION  
Under 18**

**Patient information**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Circle which option you want us to contact you regarding your appointments:

Home Phone Work Phone Cell Phone E-Mail

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

If Patient is a minor, give parents or guardians name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # years employed \_\_\_\_\_

Spouses Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Work Phone \_\_\_\_\_

**Consent for Minor**

Since \_\_\_\_\_ is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by Dr. Kopczyk, Vieth, Majors and or their legally qualified associates. Such authorization is hereby granted to administer any treatment, anesthetics, and perform such procedures or otherwise manage my child as may be deemed necessary. I understand I will be consulted before any treatment is done.

Parent's / Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_