Tiny Tooth Dental
Even the smallest teeth deserve the finest care

PARENT/GUARDIAN REGISTRATION

Mother/Guardian _____

Address if different from child_____

_____

Birthdate_____ SS#_____

Cell Phone_____

Email_____

Dental Insurance _____

Employer_____

Subscriber ID# _____

Father/Guardian_____

Address if different from child _____

_____

Birthdate_____SS#_____

Cell Phone_____

Email_____

Dental Insurance _____

Employer_____

Subscriber ID#_____

OTHER CONTACTS

If we are unable to contact you or in the event of an emergency, who should we contact?

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

AUTHORIZATIONS

To the best of my knowledge, the registration information is complete and correct. I understand that it is my responsibility to inform the doctor if my minor/child ever has a change in health.

Minor/Child Consent
I am the parent, guardian, or personal representative of the minor(s)/child(ren) listed in these registration forms and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether I am present when the treatment is rendered or not.

Insurance Assignment and Release
I certify that my dependent is covered by the insurance company or state program listed above and assign directly to **Dr. Joseph C. Tuazon** all insurance benefits, if any, otherwise payable to me for services rendered. **I also understand that I am financially responsible for all changes whether paid by insurance or not.** I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to patient's insurance company(ies) and their agent to obtain payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the doctor/patient relationship is severed or terminated.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Relationship to Patient