

PLEASE FILL IN THIS FORM AND RETURN IT BY MAIL PRIOR TO THE DAY OF THE APPOINTMENT

**PATIENT REGISTRATION FORM**

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TELL US ABOUT YOUR CHILD

Child's name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Male  Female   
Child's birthday \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Would you like to receive reminders about your child's appointment by: Text Message  E-mail  Home  Other   
Child's home number \_\_\_\_\_ Social Security # \_\_\_\_\_ Number of Siblings \_\_\_\_\_  
What does your Child enjoy? \_\_\_\_\_

WHO IS ACCOMPANYING THE CHILD TODAY?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Do you have legal custody of the child? Yes  No   
In case of emergency, contact (Name and phone number): \_\_\_\_\_ If no, name of legal guardian \_\_\_\_\_  
Whom may we thank for this referral? \_\_\_\_\_

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_ How long? \_\_\_\_\_  
Employed by: \_\_\_\_\_ How long? \_\_\_\_\_  
Occupation: \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_  
Business Phone# \_\_\_\_\_ Home Phone# \_\_\_\_\_ Mobile# \_\_\_\_\_

PRIMARY DENTAL INSURANCE COMPANY

Insurance Co. name: \_\_\_\_\_ Insurance Co. phone# \_\_\_\_\_  
Insurance Co. address: \_\_\_\_\_ Group # (plan, local, or policy#) \_\_\_\_\_  
Insured's name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Insured's birth date: \_\_\_\_\_ SS# \_\_\_\_\_ Insured's Employer \_\_\_\_\_

SECONDARY DENTAL INSURANCE COMPANY

Insurance Co. name: \_\_\_\_\_ Insurance Co. phone# \_\_\_\_\_  
Insurance Co. address: \_\_\_\_\_ Group # (plan, local, or policy#) \_\_\_\_\_  
Insured's name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Insured's birth date: \_\_\_\_\_ SS# \_\_\_\_\_ Insured's Employer \_\_\_\_\_

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Ramaswami, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual amount billed for services and may not cover all services provided. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payer.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE