Hughes Dental Group
Personalized & Comfortable

1580 S. WINCHESTER BLVD.
Suite 303
CAMPBELL, CA 95008
Tel: (408) 378-3489

OFFICE USE ONLY

DATE
UPDATED _____

Child Registration *(Please Print)*

Referred by _____ Date _____

Name of Patient _____
Last First Middle Nickname

Address _____
Street Apt# City State Zip Code

Phone _____ Age _____ Date of Birth _____ Sex _____

Father's Name _____
Last First Middle Where Employed Work Phone #

Home Address _____
Street Apt# City State Zip Phone

S.S. No. _____ Father S.S. No. _____ Mother

Birth Date _____ Birth Date _____

Mother's Name _____
Last First Middle Where Employed Work Phone #

Home Address _____
Street Apt# City State Zip Phone

Have any of your children been seen in this office? ❒ Yes ❒ No

List Their Names _____

I understand that where appropriate, credit bureau reports may be obtained.

Is Patient Covered by
Insurance? If so _____
Name of Insurance Co. Policy or ID # Subscriber Name

_____
Name of Insurance Co. Policy or ID # Subscriber Name

School: (If Full-time Student -- 19 and older) _____

The policy in our office is that the parent who requests treatment for the child is responsible for all fees for service rendered.

_____ _____
Signature of Parent Requesting Care Date