KIAMESHA MCCLELLAN, D.D.S.
LYNTHIA STEWART, D.D.S.

2200 MORRISS RD., SUITE 150
FLOWER MOUND, TX 75028
PHONE (972) 539-4290

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME_____ FIRST_____ M.I._____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME TELEPHONE_____ SOCIAL SECURITY #_____

EMPLOYER_____ WORK TELEPHONE_____

BIRTHDATE_____ AGE_____ SEX (Please circle) Male Female

RESPONSIBLE PARTY - HOLDER OF INSURANCE POLICY

LAST NAME_____ FIRST_____ M.I._____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME TELEPHONE_____ WORK/ALT. PHONE_____

SOCIAL SECURITY #_____ EMPLOYER_____

BIRTHDATE_____ SEX (Please circle) Male Female

PRIMARY INSURANCE COMPANY_____ PHONE #_____

GROUP NUMBER#_____

SECOND PARENT/GUARDIAN/EMERGENCY CONTACT INFORMATION

LAST NAME_____ FIRST_____ M.I._____

HOME TELEPHONE_____ WORK/ALT. PHONE_____

SOCIAL SECURITY #_____ EMPLOYER_____

AS A COURTESY TO YOU, WE WILL FILE YOUR CLAIM WITH YOUR INSURANCE COMPANY. HOWEVER, IT IS YOUR RESPONSIBILITY TO MAKE SURE THEY PAY YOUR BILL. IF THEY DO NOT PAY WITHIN 90 DAYS OF SERVICES RENDERED, IT THEN BECOMES YOUR RESPONSIBILITY TO PAY YOUR BILL AND HAVE THE INSURANCE COMPANY REIMBURSE YOU DIRECTLY.
ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

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Signature of Patient or Responsible Party **Date**