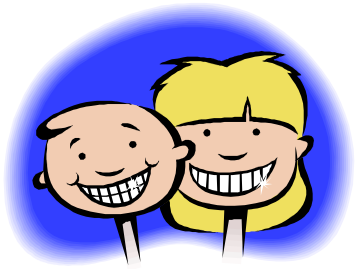

CHILD REGISTRATION

PATIENT NAME: _____ **M F**

PARENT NAME: _____

ADDRESS: _____

CITY_____STATE_____ZIP_____

(H) PHONE#:_____ (M) PHONE#_____

EMERGENCY CONTACT & PHONE#: _____

PATIENT DATE OF BIRTH: _____

INSURANCE AND FINANCIAL INFORMATION

DENTAL INSURANCE COVERAGE: **Y N** INSURANCE CO _____

INSURANCE CO. ADDRESS _____

SUBSCRIBER'S NAME: _____ EMPLOYER :_____

ID#:_____ GROUP# _____

SUBSCRIBER DOB _____

RELATIONSHIP TO PATIENT_____

Affirmation, Assignment & Release

I affirm that all information I have given today on this registration and the medical/dental form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I consent to the making of necessary x-rays, study models, photographs, and videotapes before, during, and after treatment, and to their use by Dr. Raptou for exam, study, diagnosis, treatment, documentation, for patient education and demonstration, for dental educational lectures, and in scientific papers without patient compensation.

If I have dental insurance, I hereby authorize my insurance benefits to be paid directly to Dr. Raptou and authorize his office to release any information pertaining to my dental insurance. Regardless, I understand that I am financially responsible for all charges whether or not paid by my insurance. I certify that I have read or had read to me the contents of this affirmation, assignment, and release, and realize the risks and limitations involved.

Signature _____ *Date* _____