Registration Form

Kurt W. Sturz, D.M.D., M.S.   Sturz Pediatric Dentistry

PATIENT INFORMATION

Child's Name (Last, First, Middle)		Nickname
Address		Home Phone
City	State	Zip
Date of Birth	Age	Patient's Sex: ❑ M ❑ F
School		Grade

Who may we thank for referring you to our office?

MOTHER/GUARDIAN INFORMATION

Name (Last, First)		
Social Security #		Date of Birth
Address		
City	State	Zip
Home Phone	Cell Phone	
Occupation		
Employer		Business Phone

FATHER/GUARDIAN INFORMATION

Name (Last, First)		
Social Security #		Date of Birth
Address		
City	State	Zip
Home Phone	Cell Phone	
Occupation		
Employer		Business Phone

ACCOUNT INFORMATION

Person financially responsible for account:	Dental Insurance? ❑ Yes ❑ No *If yes, please fill out information below.*
Primary Carrier: ❑ Mother ❑ Father ❑ Other ____	
Insurance Company	Group # / SSN
Secondary Carrier: ❑ Mother ❑ Father ❑ Other ____	
Insurance Company	Group # / SSN

I request and authorize Dr. Sturz to examine and provide dental treatment to my child. This includes the taking of dental radiographs as deemed necessary by the dentist to diagnose and/or treat my child's dental problem. I authorize the release of information regarding the diagnosis and treatment of my child's dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my child's behalf. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Sturz will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature of Parent/Guardian ____ **Date** ____________________

I have received a copy of the Dental Materials Fact Sheet as required by law.

Signature of Parent/Guardian ____ **Date** ____________________