



A WINNING SMILE DENTAL CENTER

Greg C. Witte, D.M.D.
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(502) 969-9897
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CHILD'S REGISTRATION FORM

Date _____

Child's Name _____ Nickname _____ DOB _____ Sex M F

Child's Address _____ City _____ State _____ Zip _____

Child's SS# _____ School _____ Grade _____

E-mail Address _____ Cell Phone _____

Father's Full Name _____ Father's SS# _____

Father's Address if Different From Child's _____ Home# _____

Father Employed by _____ Work# _____

Employer's Address _____ Father's DOB _____

Mother's Full Name _____ Mother's SS# _____

Mother's Address if Different From Child's _____ Home# _____

Mother Employed by _____ Work# _____

Employer's Address _____ Mother's DOB _____

Person Responsible For Account _____ Relationship to Patient _____

Primary Insurance Company and Address _____

Secondary Carrier (if Applicable) _____

Whom May We Thank For Referring You _____ Relationship if any _____

Acknowledgment:

I consent to treatment as necessary or desirable for the care of the patient named above, including but not limited to x-rays, drugs, medicine, performance of treatment and use of lab, x-rays or other studies that may be used by Dr. Witte or his staff. I acknowledge full responsibility for the payment of service and agree to pay AT TIME OF SERVICE unless other arrangements are made prior to the time of service.

Signed: _____

Must be 18 years or older