Eli M. Rachlin, DDS
NJ Specialty Permit # 5229
595 Chestnut Ridge Road, Suite #5
Woodcliff Lake, NJ 07677
Tel: (201) 391-4441 Fax: (201)391-3303

REGISTRATION FORM

About Your Child

Date_____

Child's Name_____Preferred Name_____
Date of Birth_____ **O** Male **O** Female
Home Address_____ Home Phone#_____
City_____ State_____ Zip Code_____
Pets, Hobbies, Interests _____
_____
How did you hear about our office? _____

Parent or Guardian Information ___Mother ____Stepmother ____Guardian

Name_____ DOB _____
Occupation_____Employer_____ Work Phone #_____
SS#_____ Cell Phone # _____ Home Phone#_____
Marital Status_____ Email_____
Home Address_____

Parent or Guardian Information ___Father ____Stepfather ____Guardian

Name_____ DOB _____
Occupation_____Employer_____ Work Phone #_____
SS#_____ Cell# _____ Home Phone#_____
Marital Status_____ Email_____
Home Address_____

Primary Dental Insurance Information *(note: if you are unsure about this, please ask us)*

Subscriber's Name_____Soc. Security#_____ Relationship to child _____
Subscriber's DOB_____ Insurance Company Name _____
Group #_____ Insurance Co. Phone # _____

Authorization and Release

As the parent or legal guardian of the above-named patient, I hereby give my consent for Dr. Eli Rachlin to perform dental service and treatment (s) on the child named, including any necessary radiographs.
I am responsible for payment in full at the time of service, unless prior arrangements have been approved. To facillitate the filing of my dental insurance claims, I hereby authorize the release of confidential information to my dental insurance agency. I hereby authorize payment of insurance benefits directly to Chestnut Ridge Pediatric Dental. In the event of payment default for services previously rendered, I agree to pay all collection and/or legal fees incurred in an attempt to collect on this amount.

_____ _____ _____
Signature of parent or legal guardian **Date** **(Please print name)**