ANDREW C. DREYER, DDS, MS
PERIODONTICS & DENTAL IMPLANTS

Date _____

REGISTRATION FOR MINORS

Last Name | First | MI | Date of Birth

Mailing Address | City | State | Zip

Home Phone | Cell Phone

General Dentist | City | How Long?

GUARDIAN INFORMATION

Child Resides With: Both Parents _____ Mother _____ Father _____ Other _____

Mother/Guardian | Date of Birth

Father/Guardian | Date of Birth

Mother Phone # | Father Phone #

E-Mail Address

DENTAL INSURANCE INFORMATION

Primary Insurance | Secondary Insurance

Primary Ins. Company Address | Secondary Ins. Company Address

Group Name/Number | Group Name/Number

PERSONAL INFORMATION

Whom may we thank for referring you to our office? _____

How would you prefer we address you (e.g. first name, nickname, or more formally)? _____

Is there some way in which we may make treatment visits easier for you? _____