Akoya Pediatric Dentistry
15761 Sheridan St, Suite A, Southwest Ranches, FL 33331
(954) 799-6212

Child Registration

PATIENT INFORMATION

PATIENT FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) *

MM/DD/YYYY

PATIENT LAST NAME

GENDER:

CHILD'S HOME ADDRESS: *

IS THE PATIENT HOME SCHOOLED:

- ◯ Yes
- ◯ No

PLEASE UPLOAD A PHOTO OF THE PATIENT:

Upload image

PARENT/GUARDIAN CONTACT INFORMATION

NAME:

RELATIONSHIP TO PATIENT:

ARE YOU THE PATIENT'S GUARDIAN:

- ◯ Yes
- ◯ No

CELL PHONE NUMBER

(___) ___-____

EMAIL

Additional contact information

NAME:

CELL PHONE NUMBER

(___) ___-____

RELATIONSHIP TO PATIENT:

EMAIL

ADDITIONAL INFORMATION

IS THIS THE PATIENT'S FIRST DENTAL VISIT?

- ◯ Yes
- ◯ No

DATE OF LAST DENTAL VISIT:

HOW DID YOU HEAR ABOUT US?

NAME OF THE PERSON ACCOMPANYING THE CHILD TODAY?

ARE YOU THE LEGAL GUARDIAN:

- ◯ Yes
- ◯ No

Thank you for choosing Akoya Pediatric Dentistry for your child's dental needs!

Co-pays & deductibles are to be paid at each appointment as services are rendered. For the convenience of our patients, we accept cash, AMerican Express, MasterCard, Visa, & Discover.

We strongly urge you to thoroughly review your insurance plan guidelines/booklet prior to your appointment. There is no direct relationship between our office and your insurance company. As a courtesy to our patients, we will electronically file your dental insurance claims and bill your dental insurance company for the treatment your child receives. However, in the event the insurance company doesn't pay the estimated portion of the bill for any reason, the balance will become the patient's responsibility and will be billed directly to you. We recognize that under unusual circumstances, an account balance may be incurred. This office requires that all outstanding balances be paid in full within thirty [30] days unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us in thirty [30] days, further action may be taken with a collection agency or with Small Claims COurt. You will be responsible for any fees incurred including court costs and attorney fees.

I [PARENT/GUARDIAN/PATIENT] NAME:

hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

By selecting here and signing this form, I hereby certify that I am covered by the above Insurance company and I assign directly to Akoya Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and/or deductible that my insurance does not cover.

By selecting here and signing this form, I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

DRAW YOUR SIGNATURE INTO THE BOX BELOW *

Clear

RELATIONSHIP TO THE PATIENT

NAME IF NOT THE PATIENT

DATE

04-29-2025