"let our family care for yours"

Rossy Pediatric Dentistry

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Let's Get to Know Your Child

Today's Date: _____

Child's Name: _____

Birthdate: ____/____/_____ ☐ Male ☐ Female

Preferred Name: _____

Home Phone Number: _____

Address: _____

City_____ State_____ Zipcode_____

Last Dental Visit: _____/_____/_____ Where?_____

Who is Accompanying this Child?

Name: _____

Relationship to Patient: _____

Preferred method of contact:

☐ Phone ☐ Email ☐ Text ☐ Cell

How did you hear about us?

☐ Referred by Doctor
☐ Referred by Family/Friend
Who can we thank for referring you? _____
☐ Web
☐ Other: _____

Parent Information

Mother's Name: _____

Birthdate: ____/____/_____ Home#_____

Work#_____ Cell#_____

SSN: _____

Occupation: _____

Email: _____

Parents' Marital Status: ☐ Single ☐ Married

Father's Name: _____

Birthdate: ____/____/_____ Home#_____

Work#_____ Cell#_____

SSN: _____

Occupation: _____

Email: _____

☐ Divorced ☐ Partnered

Primary Dental Insurance

Policy Owner's Name: _____

Policy Owner's Birthdate: _____/ _____/ _____

Insurance Company Name: _____

Policy Owner's Employer: _____

Insurance Company Address: _____

_____

Insurance Company Phone#: _____

Secondary Dental Insurance

Policy Owner's Name: _____

Policy Owner's Birthdate: _____/ _____/ _____

Insurance Company Name: _____

Policy Owner's Employer: _____

Insurance Company Address: _____

_____

Insurance Company Phone#: _____

I certify that my child is covered by the above insurance company and I assign directly to Rossy 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 co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian Date