# Rogers Family Dentistry

Child's Name _____ Prefers to be called _____
Last First Middle

Home Address _____ Zip _____

DOB _____ Phone _____ Sex M F Marital Status of parents S/M/D/W/Sep

If divorced or separated, who has legal custody of child? _____

Father's Name _____ SS# _____ DOB _____

Employer _____ Address _____ Phone _____

Mother's Name _____ SS# _____ DOB _____

Employer _____ Address _____ Phone _____

In case of emergency, contact _____ Phone _____

Who referred you to our office _____
Name Relation Phone

Child's hobby or interests _____

***Primary Dental Insurance Coverage*** ***Please do not give Medical Insurance***

Subscriber Name _____ Relation to Patient _____

Employer Name _____ Group # _____
Insurance Co. _____ Address _____

***Secondary Dental Insurance Coverage Please do not give Medical Insurance***

Subscriber Name _____ Relation to Patient _____
Employer Name _____ Group # _____
Insurance Co. _____ Address _____

*Please sign the authorization below:*

**I direct the insurer to pay Rogers Family Dentistry all benefits due as the result of my claim. Although I may be covered by insurance, I am aware that I am personally responsible for all charges. I acknowledge receipt of a copy of Rogers Family Dentistry's Financial Policy.**

**I authorize Rogers Family Dentistry to release all necessary information to my insurance company regarding my diagnosis and treatment. I also authorize Rogers Family Dentistry to discuss and/or release information to any other dentist, physician or pharmacist involved in my treatment. I acknowledge receipt of Rogers Family Dentistry's "Notice of Privacy Practices". A photostatic copy of this authorization is as valid as the original.**

**Signature of Responsible Party:**

_____ **Date** _____