ROGERS DENTAL CENTER

ABOUT YOUR CHILD:

TODAY'S DATE: _____

Name: _____ _____ _____ (_____)
Last **First** **MI** **Preferred-name**

O Female **O** Male Birth Date: _____

Address: _____

_____ _____ _____
City **State** **Zip Code**

School (if any): _____ Grade: _____ Age: _____

What is your child's favorite sport or activity? _____

Favorite toy and/or hobby? _____

Who may we thank for referring the patient? _____

Mother's name: _____ Cell phone: _____ ☐

E-Mail address: _____

Father's name: _____ Cell phone: _____ ☐

E-Mail address: _____

Best way to confirm appointments (mark all that apply): **O** Phone call **O** Text **O** Email

****Please place a check √ in the box above noting *which* parent to notify for future appointments****

Guardian's Signature:_____ **Relationship to child:** _____

DENTAL INSURANCE INFORMATION:

Insurance company name: _____ Employer of policy holder: _____

Insurance company address: _____

_____ Phone: _____

Policy holder's name: _____ Policy holder's birth date: _____

Policy holder's ID/ Social Security #: _____ Group #: _____

Does the patient have a Secondary Insurance? **O** Yes **O** No

If so, which Insurance company is it through? _____

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced notice of two business days. We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in a $50 charge and the discontinuation of services. Guardian's Initials: _____