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PEDIATRIC DENTAL ASSOCIATES, P.C.

General Information and Insurance Information Sheet

All information must be completed below in order for us to file your insurance.
Please have your insurance card available for us to copy.

Mothers Information:
Name: _____
Date of Birth: _____
SSN: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Employer: _____
Work Address: _____
_____

Fathers Information:
Name: _____
Date of Birth: _____
SSN: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Employer: _____
Work Address: _____
_____

DENTAL INSURANCE:
Name of card holder: _____
Date of Birth: _____ SSN: _____
Employer: _____
Insurance Company: _____ ID#: _____
Group#: _____ Toll Free #: _____

CHILD'S INFORMATION: (please list all children who are patients at P.D.A.)
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

I hereby authorize payment directly to the above-named healthcare provider. I understand that I am financially responsible for any portion of the charges not covered by insurance, including co-pays, non-covered expenses and deductibles at time of service.

Signature: _____ Date: _____