

Pediatric Dental Associates Of Southbury, L.L.C.

Antonio Lepore, Jr., DDS

Annemarie Delessio-Matta, DMD

YOUR CHILD

Child's Name _____

Nickname _____

Birth date _____ Age _____

Sex _____

School _____ Grade _____

Home Address _____

City, State, Zip _____

Home Tel # _____

Cell or Alt. # _____

Circle Appropriate Response:

Mother Stepmother Guardian
Married Single Divorced

Name _____

Home Phone _____

Work Phone _____

Employer _____

Soc. Sec. # _____

Name of Patient's siblings _____

PRIMARY DENTAL INSURANCE

Insured's Name _____

Relationship _____

Birth date _____

Soc. Sec. # _____

Employer _____

Emp. address _____

Emp. Tel. # _____

Ins Co. Name _____

Ins. Co. Address _____

Subscriber # _____

Group # _____

Father Stepfather Guardian
Married Single Divorced

Name _____

Home Phone _____

Work Phone _____

Employer _____

Soc. Sec. # _____

Financial Arrangement

All payment arrangements must be made in advance. In the case of default on payment, I agree to pay collection costs and all attorney fees. I authorize the dentist to release any information to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dentist. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature _____ Date _____