

PLEASE SUPPLY ALL REQUESTED INFORMATION. WE HAVE A VERY HUNGRY COMPUTER.

MINOR CHILD PATIENT INFORMATION

(This form is for children who have not reached their eighteenth birthday)

CHILD'S NAME _____
LAST FIRST MI NICKNAME

ADDRESS _____
NUMBER & STREET CITY STATE ZIP

_____/_____/_____ (____)____-____ M F ____/____/____ WHICH PARENTS LIVE WITH CHILD? M F BOTH
* SOC. SEC. NUMBER HOME PHONE GENDER DATE OF BIRTH

*You may decline to give your child's Social Security Number. This may affect the filing of insurance claims or the granting of credit.

RESPONSIBLE PARTY INFORMATION (This is the person who brings the child to the office for the first visit)

NAME _____
LAST FIRST MI MR. MS. MRS. MISS DR.
PREFERRED TITLE - CIRCLE ONE

ADDRESS _____
NUMBER & STREET CITY STATE ZIP

(____)____-____ (____)____-____ (____)____-____ W H (____)____-____
HOME PHONE BUSINESS PHONE EXT FAX CELL PHONE

Social Security Number _____-____-____

*You may decline to give your Social Security Number. This may affect the filing of insurance claims or the granting of credit.

E-MAIL ADDRESS (EXACTLY, PLEASE) _____ M F ____/____/____
GENDER DATE OF BIRTH

EMPLOYED: FULL TIME PART TIME RETIRED NOT EMPLOYED OUTSIDE THE HOME STUDENT

RESPONSIBLE PARTY'S EMPLOYER _____ EMPLOYER'S ADDRESS - STREET & NUMBER _____ CITY _____ STATE _____ ZIP _____

- I LEARNED OF YOUR OFFICE FROM:** ANOTHER PERSON (NAME) _____
- DR. ROSS' WEB SITE FACEBOOK TWITTER DR. ROSS' BLOG YELLOW PAGES
- DEAR DOCTOR MAGAZINE OR DEAR DOCTOR WEB SITE SEARCH ENGINE (which?) _____
- OTHER (PLEASE SPECIFY) _____

"I understand and consent that x-rays, photographs, slides, videos and/or other documentation will be used as a record of my child's care and may be used for educational purposes by Dr. Ross in lectures, demonstrations, display albums, professional publications, and as illustrations for education on the office's web sites. My child's name and/or other identifying information will kept confidential unless I specifically consent otherwise. I do not expect compensation, financial or otherwise, for the use of these materials."

"I authorize the release of dental and/or medical records of my child that are in the possession of any dental, medical or other health facility to the office of Dr. Steven B. Ross".

Office to contact:: _____ Address _____

Signature _____ Date ____/____/____

PLEASE TELL US ABOUT YOUR DENTAL CONCERNS AND WISHES FOR YOUR CHILD: