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Suite 160B
Chantilly VA, 20151
Ph: 403-203-1000
Fax: 703-230-0509

12700 Black Forest Lane
Suite 304
Woodbridge, VA 22192
Ph: 703-670-1991
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Mala A. Britto, DDS, MS
Board Certified Pediatric Dentist

Patient Information

A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.

By completing this form thoroughly, you are assisting us to provide the most friendly, safe and efficient care for your child.

Child Information

Child's name (First)________________ (Middle Initial)________(Last) ________________

Nickname ________________Child's date of birth ________________ **Male / Female**

Primary phone number ________________ Secondary Phone number ________________

Home address ________________

City ________________State________Zip Code________

Parent Information

Parent#1 Name (First)________________ (Middle Initial)________(Last)________________

Date of birth________ Social Security #________Mobile Number________

Employer ________________ Work phone # ________________

Parent#2 Name (First)________________ (Middle Initial)________(Last) ________________

Date of birth ________ Social Security #________ Mobile Number________

Employer ________________ Work phone number ________

Email address ________________

Who referred you to our office? ________________ Family dentist name ________

Financial Information

Primary Insurance Company: ________________ Phone number ________

Insurance Company Address: ________________

City ________________State________Zip Code________

Insurance Policy Holder: ________________ Policy Holders Date of birth ________

Employer ________________

ID # ________________ Group # ________________

Secondary Insurance Company: ________________ Phone number ________

Insurance Company Address: ________________

City ________________State________Zip Code________

Insurance Policy Holder: ________________ Policy Holders Date of birth ________

Employer ________________

ID # ________________ Group # ________________

During your visit we will only collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account. A returned check fee of $35 will be charged for any returned check and you will have 30 days to clear up the balance before it could be sent to collections. In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. **I have read and understand this insurance policy. I also hereby authorize my insurance company to send payments directly to Britto's Children's Dentistry and understand that I am responsible for all remaining balances.**

________________ Signature

________________ Date

www.drbritto.com
Email : frontdesk4drbritto@Gmail.com