ROCKBRIDGE AREA FREE CLINIC
25 Northridge Lane, Suite 3, Lexington, VA 24450
540.464.8700.ext 112
Pediatric Dental Program Application Form

Date of Application: _____

Name of parent(s): _____

Address: _____

City: _____,VA Zip: _____
Voting District: _____
Phones: Home: _____
Cell: _____
Work: _____

How many adults reside in your household including yourself? _____
How many children reside in your household? _____

Children:

Name:	Relationship:	Birth Date:	Sex:	Social Security Number:	Race:

Does your child/children have dental insurance? ___ Yes ___ No

What is your monthly gross household income? $_____

Are you willing to participate in a parent/child/dental staff meeting prior to your child's first appointment? ___Yes ___No

Printed name of person completing this form: _____

Signature of person completing this form: _____
Note: You may be asked to provide proof of household income.

Patient Fee Per Visit: _____
Date Eligibility Card Issued: _____

The Rockbridge Area Free Clinic provides services without regard to the patient's age, sex, race, color, religion, national origin, or marital status.