BCA PEDIATRIC DENTAL PROGRAM APPLICATION

FAMILY INFORMATION

CHILD'S NAME:		SEX: M F
ADDRESS:		CITY:
ZIP CODE:	PHONE:	BIRTH DATE:
EMAIL ADDRESS:		
FATHER:	EMPLOYER:	
MOTHER:	EMPLOYER:	
DENTAL INSURANCE (Company & Address):		
NUMBER & AGES OF DEPENDENTS:		

MONTHLY INCOME		**MONTHLY EXPENSES**	
Take Home Pay:	$	Rent or Mortgage:	$
Pension:	$	Taxes & Insurance:	$
Social Security:	$	Food & Household:	$
Help from others:	$	Auto Expense:	$
Other Income:	$	Utilities:	$
(Explain):		Other:	$
		(Explain):	
TOTAL INCOME:	$	**TOTAL EXPENSES:**	$

*Please attach proof of earnings with this application (pay stubs, tax return, etc.)

DENTAL HISTORY

When was your child's last dental visit?

- During that visit, was any treatment recommended (i.e. fillings, root canals, extractions)?
- If so, what treatment and was it completed?

Rate how you believe your child would behave during dental treatment:

Uncooperative 1 2 3 4 5 6 7 8 9 10 **Cooperative**

Is your child experiencing any dental-related pain (toothaches, swollen gums, etc.)?

Did either parent have any history of dental-related issues (i.e. cavities, fillings, root canals, extractions)? If so, describe:

Other comments to support request for care may be written on the back.

PLEASE NOTE: Child must be between the ages of 1-18 to be eligible for our program.

RETURN TO: BCA, Turnabout Shop, 10052 San Pablo Ave., El Cerrito, CA 94530