Children's Dentistry & Orthodontics

We Make Smiles

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I hereby authorize Dr. Rosenblum, Dr. Levin, Dr. Hasty, Dr. Wright and/or Dr. Nair and such assistants as they may designate to treat this patient using procedures including restorative, oral surgery, and patient management techniques that are reasonable, necessary and deemed advisable by the doctors.

I understand that I am financially responsible for all services rendered. It is office policy to accept insurance assignment for the amount my insurance will pay. I am requested to pay any deductible not met, and my share of fees at time of treatment. The computer files the insurance claim the day after my child's date of service. The office requests PAYMENT IN FULL on the insurance accounts after sixty days have lapsed from the date of filing. It is necessary to follow-up on my insurance claim due to no payment, I realize this is my responsibility, not the doctor's, or this office.

I accept responsibility for payment of the dental services performed. The parents or guardians of the patient are responsible for payment of the account. The office will gladly file your dental insurance; however the parents or guardians are responsible for all fees regardless of insurance coverage. If the account is referred for collection, the parents or guardians will be responsible for their balance plus all costs incurred collecting the account (which include attorney fees of 33 1/3% plus court fees).

I authorize release of any information relating to this claim.

I authorize payment directly to Drs. Rosenblum, Levin, Hasty, Wright and Nair.

I permit a copy of this authorization to be used in place of the original.
(This applies to any request from my insurance carrier.)

INTEREST IS COMPUTED ON UNPAID BALANCE AT THE RATE OF 18% ANNUALLY (1-1/2% MONTHLY)

_____
SIGNATURE OF PARENT OR GUARDIAN

_____
DATE

PATIENT INFORMATION

Today's Date _____

Patient's Name _____ Date of Birth _____

Name of Child's Physician _____ Sex: ☐ Male ☐ Female

Covered by Dental Insurance? ☐ Yes ☐ No Patient's Cell# _____

HAS CHILD HAD ANY OF THE FOLLOING?

	Yes	No		Yes	No
Bleeding Problems	☐	☐	Speech Problems	☐	☐
High Fever	☐	☐	Neurological Problems, Seizures	☐	☐
Respiratory Problems, Asthma	☐	☐	Sickle Cell Anemia	☐	☐
Heart Problems	☐	☐	Diabetes	☐	☐
Hearing or Sight Disorders	☐	☐	Cold Sores - Fever Blisters	☐	☐
Allergies	☐	☐	Physical Handicap	☐	☐

Is your child allergic to Penicillin? _____

Please list any other medications your child is allergic to _____

Please list any medicine your child is taking _____

Is your child up to date on their tetanus vaccine? ☐ Yes ☐ No

Is this your child's first visit to a dentist? ☐ Yes ☐ No Number of children in family _____

If not, has your child had any unfavorable dental experiences? ☐ Yes ☐ No

Does your child have a dental problem or toothache now? ☐ Yes ☐ No If yes, please explain:

_____

Does your child have any other desease, condition or problems that we should know about?

_____

Which of the following best describes your child?

☐ Advanced in learning process ☐ Progresses normally ☐ A slow learner

Who may we thank for referring you? _____

FAMILY HISTORY

Father's Name _____

SS# _____ Date of Birth _____

Street Address _____

City /State/Zip _____ Home Phone # _____

Employer _____ Work Phone # _____

Insured's Name _____ Cell Phone # _____

Name of Dental Insurance Co. _____

Policy / Group #, if different than SS# _____

Mother's Name _____

SS# _____ Date of Birth _____

Street Address _____

City / State / Zip _____ Home Phone # _____

Employer _____ Work Phone # _____

2nd Insured's Name _____ Cell Phone # _____

Name of Dental Insurance Co. _____

Policy / Group #, if different than SS# _____

Child resides with: ❑ Father ❑ Mother ❑ Both

Email: _____