

We Make Smiles Children's Dentistry & Orthodontics

Rosenblum, Levin,
Barney & Hasty

1055 Kempsville Road
Virginia Beach, Virginia 23464
(757) 474-1200

I hereby authorize Dr. Rosenblum, Dr. Levin, Dr. Barney and/or Dr. Hasty and such assistants as they may designate to treat this patient using dental 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 the 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. If 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 payment directly to Drs. Rosenblum, Levin, Barney & Hasty.

I authorize release of any information relating to this claim.

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 (1.5% 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 Social Security #: _____

HAS CHILD HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Fever	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems, Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing or Sight Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores - Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Physical Handicap	<input type="checkbox"/>	<input type="checkbox"/>

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 disease, conditions 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 # _____

Employer's Address _____ Cell Phone # _____

Name of Dental Insurance Co. _____

Policy #, if different than SS# (Group#) _____

Mother's Name _____

SS# _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____ Home Phone # _____

Employer _____ Work Phone # _____

Employer's Address _____ Cell Phone # _____

Name of Dental Insurance Co. _____

Policy #, if different than SS# (Group#) _____

Child resides with: Father _____ Mother _____ Both _____