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 SS# ____________

HAS CHILD HAD ANY OF THE FOLLOWING?

	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

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?

____

WE APPRECIATE YOUR REFERRALS!

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 / Group #, if different than SS# ____________

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 / Group #, if different than SS# ____________

Child resides with: ☐ Father ☐ Mother ☐ Both

22216 CDO103 1/06

Email: ____________

We Make Smiles

Children's Dentistry & Orthodontics

MARK S. LEVIN, D.D.S. • MICHAEL F. HASTY, D.D.S., M.S.
SCOTT H. ROSENBLUM, D.D.S., M.P.H. • BRITTANY M. WRIGHT, D.D.S., M.S.
1055 KEMPSVILLE ROAD • VIRGINIA BEACH, VA 23464 (757) 474-1200

I hereby authorize Dr. Rosenblum, Dr. Levin, Dr. Hasty and/or Dr. Wright 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 and Wright

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