

**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	<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, 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: \_\_\_\_\_

# We Children's Dentistry Make Smiles & Orthodontics

MARK S. LEVIN, D.D.S.  
MICHAEL F. HASTY, D.D.S., M.S. • SCOTT H. ROSENBLUM, D.D.S., M.P.H.  
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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)

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SIGNATURE OF PARENT OR GUARDIAN

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DATE