Welcome to Our Practice!

We are pleased to welcome you and your child to our practice. Please take a few moments to fill out this forms as complete as possible. If you have any question, we would be more than happy to assist you.

Patient Information

Child's Name: ___________________________________ Age: _______ Days Weeks Months (Circle one)
Date of Birth: ___________/___________/___________ Sex: Male ☐ Female ☐
Whom may we thank for referring you? ____

Parents Information

Mother: ___________________________________ Father: ____
Home/Mailing Address: ____
City: ____________________________________ State:______________ zip code:______________________
Cell Phone #: ( ) ____________________ Home Phone #: ( ) _______________________________
Email Address: ____
Parent Responsible for the Account:_______________________________ DOB:_______/_______/_______

Dental Insurance Information

As a courtesy to our patients, we are happy to work with most dental insurance carriers and help you maximize your benefits. However, if we do not receive payment from your insurance within 45 days, you will be responsible for the payment of any balance up to the total submitted charges of your child's treatment. Any copayments or full payment is expected at the time services are rendered, unless prior arrangements have been pre-approved.

Insurance Company Name: ____________________________ Customer Service # ( ) _______________
Subscriber: ______________________________ DOB:_____/_______/_______ ID#:___________________
Employer:___________________________________ Group #: _______________________________________

My signature below indicates I fully understand the above insurance statement and I authorize Lexington Smile Studio to bill my dental insurance for any services rendered and receive direct payment from the company if applicable.

Signature: _____________________________________ Today's Date: _________________________________

Medical Insurance Information

Most Medical Insurance companies will not cover treatment in our office because we are a general dental practice. Sometimes, the dental insurance needs medical insurance information to process your claim.

Insurance Company Name: ____________________________ Customer Service # ( ) _______________
Subscriber: ______________________________ DOB:_____/_______/_______ ID#:___________________
Employer:___________________________________ Group #: _______________________________________

*****Please provide a state ID and Insurance cards to the front desk personnel to make copies*****

PLEASE CONTINUE TO THE BACK SIDE OF THIS FORM. THANK YOU.

Medical History

Pediatrician Name: ______________________________ Phone #: (   ) __________________________

Date of last visit: _______________ Has your child had any operations or serious illness? Y   N

If yes, please explain.: ____

Has your child ever had blood transfusion? Y   N   Does your child have current immunization? Y   N

Please check if your child has had any of the following:

- ❏ AIDS/HIV Positive
- ❏ Anemia
- ❏ Asthma
- ❏ Atopic (allergy prone)
- ❏ Blood disease
- ❏ Cancer
- ❏ Chicken Pox
- ❏ Convulsions/Epilepsy
- ❏ Cough, Persistent
- ❏ Cough up blood
- ❏ Diabetes
- ❏ Fainting
- ❏ Food allergies
- ❏ Hearing Impairment
- ❏ Heart Problems
- ❏ Hemophilia
- ❏ Other abnormal bleeding
- ❏ Kidney disease
- ❏ Liver disease
- ❏ Latex Allergies
- ❏ Respiratory Disease
- ❏ Scarlet fever
- ❏ Shortness of breath
- ❏ Sinus problems
- ❏ Skin rash
- ❏ Spina Bifida
- ❏ Thyroid disease
- ❏ Tonsilitis
- ❏ Tuberculosis

Is your child taking any medication? (Please list) ____

Does your child has any drug allergy? ____

Are there any health issues that we should be made aware of? ___________________________________

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this form will be used by the dentist to help determine appropriate and healthful dental treatment.   If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by insurance.

I authorize Dr. Rosenberg / Lexington Smile Studio to utilize pictures and or video taken during my child's visit for research and educational purposes. Their identity will not be disclosed without expressed written consent.

Signature: ____ Date: ________________________________