BRUSH SMILES FLOSS DENTIST HEALTHY
DENTIST HEALTHY GUMS HYGIENIST

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name ______________________________ Soc. Sec. # ____________
Last Name *First Name* *Initial*

Address ____

City ____________ State ______ Zip __________ Phone ____________

Sex ❑ M ❑ F Age ________ Birthdate ____________ School ____________

Grade ____________ Hobbies/Sports ______________________________

Whom may we thank for referring you? ______________________________

Notify in case of emergency ____________ Home Phone __________ Work Phone __________

PRIMARY INSURANCE

Person Responsible for Account ______________________________
Last Name *First Name* *Initial*

Relation to Child ____________ Birthdate __________ Soc. Sec. # ____________

Address *(if different from child)* ______________________ Home Phone ____________

City ____________ State ______ Zip ____________

Person Responsible Employed by ______________________ Occupation ____________

Business Address ______________________ Business Phone ____________

Insurance Company ______________________ Phone ____________

Contract # __________ Group # __________ Subscriber # __________

Name of other dependents under this plan ______________________________

ADDITIONAL INSURANCE

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ____________ Relation to child ____________ Birthdate ____________

Address *(if different from child)* ______________________ Soc. Sec. # ____________

City ____________ State ______ Zip __________ Phone ____________

Subscriber Employed by ______________________ Business Phone ____________

Insurance Company ______________________ Phone ____________

Contract # __________ Group # __________ Subscriber # __________

Name of other dependents under this plan ______________________________

Please complete both sides.

TOOTHPASTE CHECKUP NO CAVITIES WIDE OPEN TEETH
TEETH HYGIENIST GUMS HEALTHY DENTIST
TEETH OPEN WIDE NO CAVITIES CHECKUP
GUMS HYGIENIST TEETH OPEN WIDE NO CAVITIES
FLOSS SMILES BRUSH TOOTHPASTE
HYGIENIST GUMS HEALTHY DENTIST

BRUSH SMILES FLOSS DENTIST HEALTHY
DENTIST HEALTHY GUMS HYGIENIST

Dental History

What would you like us to do for your child today? ______________________________

____

Former Dentist ______________ Address ______________ Phone ______________

Date of last dental care ______________ Date of last x-rays ______________

How often does your child brush? ______________ Floss? ______________

Does your child experience pain or discomfort in the jaw joint? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems? ______________

Have your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your child's dental health or previous treatment ______________

____

Medical History

Child's Physician ______________ Phone ______________

Date of last visit ______________ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ______________

Is your child currently under physician care? ❑ Y ❑ N If yes, describe ______________

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ______________

Has your child ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

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
- ❑ Epilepsy
- ❑ Fainting
- ❑ Food allergies
- ❑ Headaches
- ❑ Hearing Impairment
- ❑ Heart problems Describe______________
- ❑ Hemophilia/ Abnormal bleeding
- ❑ Immunizations current
- ❑ Kidney disease or malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal, chemicals)
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Thyroid disease or malfunction
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Other______________

List medications your child is taking, if any:

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____

List drug allergies, if any:

____

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Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information 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 or not paid by insurance.

Signature ______________________________ Date ______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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AUDIO/VIDEO/PHOTO MEDIA RELEASE

For good and valuable consideration, the receipt of which is hereby acknowledged, I hereby consent to the photographing of myself, the recording of my voice, and/or the video recording of myself and the use of these photographs and/or recordings singularly or in conjunction with other photographs and/or recordings for advertising, publicity, commercial or other business purposes.

I further consent to the reproduction and/or authorization by Dr. Fawn Rosenberg and Lexington Smile Studio to reproduce and use said photographs, video recordings and recordings of my voice, for use in all domestic and foreign markets. Further, I understand that others, with the consent of Dr. Fawn Rosenberg and Lexington Smile Studio may use and/or reproduce such photographs and recordings.

I hereby release Dr. Fawn Rosenberg and Lexington Smile Studio, and any of its associated or affiliated companies, their directors, officers, agents, employees and customers, and appointed advertising agencies, their directors, officers, agents and employees from all claims of every kind on account of such use.

If Model is under 18: I certify that I, ____________________, am the parent/legal guardian of the individual named above, I have read this release and approve of its terms.

Print Name: ______________________________________

Signature: ______________________________________

Legal Guardian (if applicable) ________________________

Date: ________________________

Fawn Rosenberg, D.M.D., F.A.G.D. **Telephone: (781) 861-6008**

Cosmetic, Sedation, and Family Dentistry

Patient:_______________

Payment Policy

Payment is due at the time service is provided. Our office accepts cash, personal/certified checks, visa, Master Card and Discover. Third party financing is available upon request and approval. Returned checks will be subject to a $35 processing fee and account balances older than 45 days will be sent to collection and will be subject to a $50 collection fee.

All charges you incur are your responsibility regardless of any insurance coverage. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and education tools so that you may fully participate in maintaining optimum oral health.

Private Insurance

We must emphasize that as your dental provider, our relationship is with you, our patient, not with your dental insurance company. Your insurance policy is a contact between you, your employer and your insurance company. Our office is not a party to that contract. As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim you must provide proof of insurance and notify our office in advance to appointments of any insurance change.

Appointment Cancellations

To provide exceptional care we reserve specific amount of time for all appointments. Therefore, as a courtesy to our patients, we require at least 48 business hour notice for appointment cancellations. After two "no shows" and/or cancelations with less than 48 business hours notice, patients will be required to reserve future appointments with a credit card to charge a non-refundable fee of $50 for all future appointments.

Note: Patients under the age of 18 must be accompanied by an adult to all dental appointments.

I hereby acknowledge being the responsible party for the above named patient of Fawn Rosenberg DMD., FAGD/ Lexington smile studio. I understand that I am responsible for all costs of dental treatment rendered in all dental visits, regardless of any private insurance, as well as completely understand the "Office Policy" as noted above.

Responsible Party: ______________________ Relationship to Patient: ____________________

Signature:__________________________ Date: ________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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