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: ______________________________
Accounts Responsible Party: ________________________ DOB:________/_________/__________
License#: ________________________ State Issued: ______________ Exp Date: ______________

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

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: ______________________________

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

Cosmetic, Sedation and Family Dentistry

Thank you for scheduling this appointment with me. The goal of this consultation is to determine if there is a physical oral problem affecting your infant's breastfeeding ability.

Lactations Consultant Name: ______________________ Phone# (   ) ____________________

Please answer the following questions so that I may better understand your current breastfeeding issues.

Patient Name: _____________________________ Date of Birth: _______/______/________

Birth Weight: _____ lbs. Current Weight: _____ lbs.

Has your infant been diagnosed with a tongue or lip tie? __________________________________

Has your infant received a Vitamin K supplement? _______ What date? _________ Oral or injected? ___

Does your child have a stork bite/strawberry mark/salmon patch: ____ Where is the location? __________

Do you have any of the following? Check all that apply.

- ☐ Painful nursing
- ☐ Are your nipples bruised, cracked, blistered, blanched, flattened or lipstick shaped?
- ☐ Do your nipples bleed after nursing?
- ☐ Mastitis
- ☐ Thrush of the nipples

Do you use shield to breastfeed? ____________________

How many times per day do you breastfeed? __________ How long for each side: ________________

When nursing, is the feeding:

- ☐ Prolonged or incomplete?
- ☐ Baby bobs mouth on and off to latch
- ☐ Baby falls off the breast and sleeps
- ☐ Lip or tongue feels weak?
- ☐ Lip or tongue cycles through sucking and movement for a short time and then stops
- ☐ Baby slides off and on the nipple
- ☐ Chronic burping or flatulence
- ☐ Distended or bloated belly
- ☐ Signs of reflux such as chronic spitting up, gagging, or vomiting
- ☐ Signs of discomfort such as arching of the back or fist clenching
- ☐ Clicking noise or loss of suction while nursing
- ☐ Breast milk leaks from mouth, nose or both?
- ☐ Tongue feels like sandpaper?
- ☐ Crease mark on baby's lip after nursing?
- ☐ Strong or clamping latch?
- ☐ Infant weight loss? How much ___________________
- ☐ Do you supplement with bottle?
- ☐ Gulping Sound when nursing?
- ☐ Blistered lips?

Any other nursing concerns:

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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: ___________________

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: __________________________

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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