PEDIATRIC DENTAL ASSOCIATES OF MANHATTAN

30 EAST 40TH ST SUITE 503 New York, NY 10016 (212)-986-2039 (212)-532-2726 FAX

Today's Date: _____

Child's Name: _____ DOB: _____

Address: _____

Parent 1: _____ SS# _____ DOB: _____

Work# _____ Cell# _____ E-mail: _____

Parent 2: _____ SS# _____ DOB: _____

Work# _____ Cell# _____ E-mail: _____

Child's physician: _____ Phone# _____ Date of last visit: _____

Medications child is currently taking & dosage: _____

Please list all medications/materials that the child is allergic to: _____

HAS THE CHILD EVER HAS ANY OF THE FOLLOWING MEDICAL PROBLEMS?

☐ Y	☐ N	Abnormal Bleeding/Hemophilia	☐ Y	☐ N	Diabetes
☐ Y	☐ N	ADD/ADHD	☐ Y	☐ N	Epilepsy/Convulsions
☐ Y	☐ N	AIDS/HIV+	☐ Y	☐ N	Handicaps/Disabilities
☐ Y	☐ N	Anemia	☐ Y	☐ N	Hearing Impairment
☐ Y	☐ N	Any Hospital Stays/Operations_____	☐ Y	☐ N	Heart Murmur, Congenital heart defect
☐ Y	☐ N	Artificial Bones/Joints/Valves	☐ Y	☐ N	Tuberculosis, Measles, Chicken Pox
☐ Y	☐ N	Asthma	☐ Y	☐ N	Hepatitis Kidney/Liver Problem
☐ Y	☐ N	Autism, Asperger's	☐ Y	☐ N	Rheumatic/Scarlet Fever
☐ Y	☐ N	Cancer _____	☐ Y	☐ N	Other _____

CREDIT CARD ON FILE POLICY-Mandatory office policy

At Pediatric Dental Associates of Manhattan, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Furthermore, an "outstanding balance" charge of 1.5 percent of the total amount due will be added for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize Pediatric Dental Associates of Manhattan to charge the portion of my bill that Is my financial responsibility and for the $75 broken appointment fee if 24 hours' notice Is not given to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date _____ CVC CODE: _____

Cardholder Name _____

Signature _____

I, the undersigned, authorize and request Pediatric Dental Associates of Manhattan to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibilities. This authorization relates to all payments not covered by my insurance company for services provided to me by Pediatric Dental Associates of Manhattan.

I understand that the information that I have given is correct to the best of my knowledge, that it will be in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

I understand that I am financially responsible for payment of services rendered. I am also responsible for paying any co-payment and deductible that my Insurance does not cover if applicable. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent Guardian, self (If 18 & older) Date