Reviewed by: _____
Doctor: _____

PATIENT'S NAME: _____

X-rays may be taken as part of today's dental examination. ***I UNDERSTAND that the doctor's recommendation for x-rays is based on my child's individual needs and NOT on what the insurance company determines they will cover. I assume financial responsibility for the cost of x-rays should my insurance company deny payment.*** **Initials** _____

********If there is any reason why your child should not have x-rays taken today, please notify us.*****

MEDICAL UPDATE

1. Has there been any change in your child's health since your last visit? **YES** **NO**
   If so, please explain._____
2. Is your child currently under the care of a physician and/or taking any medication(s)? **YES** **NO**
   If so, please explain._____
3. Has there been any injury to your child's teeth, head, or neck since his/her last visit? **YES** **NO**
   If so, please explain._____
4. Are there any questions or concerns you wish to bring to the doctor's attention at this visit? **YES** **NO**
   If so, please explain._____
5. Has your child been seen by an orthodontist and if so, have recent x-rays been taken? **YES** **NO**
   Orthodontist's name and city: _____

FAMILY RECORD UPDATE **E-mail Address:** _____

I consent to Pediatric Dental Specialists using my cell phone number to (choose one or both) call or text regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent upon written request.

My cell phone number is _____ **Initials** _____

1. Has there been a change in your address? **YES** **NO**
   If so, please provide _____
2. Has there been a change in your phone number(s)? **YES** **NO**
   If so, please provide _____

INSURANCE INFORMATION

Would you like us to bill your dental insurance for today's visit? **YES** **NO INSURANCE**

If yes, please provide the following information: **NO CHANGES** **NEW INSURANCE** **DUAL INSURANCE**

Subscriber's Name:_____ Insurance Company Name:_____

Date of Birth: _____ /_____ /_____ Insurance Phone #:_____ __

Social Security or ID #:_____ Group #:_____

Employer:_____

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company(s).This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor, of insurance benefits under which I am entitled.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Child
