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Mailing Address:	City/State/Zip:	raturo tos restatoyrita a sun		1	Lot
Street Address:	City/State/Zip:	Yrrupes fast	Cell Phone:		
Parents' Names:	Who is responsible	for payment of this acco		2	
Responsible Person's Address If divorced or separated):	- Cons	or ford trailings pool o n	Home Phone:	-	
Father's Employer:		SOCIA	I SEC #	1	
Employer's Address:		Committee year in the	Bus. Phone:		
Nother's Employer:	jald Cantalana yan in telepa	SOCIA	L SEC. #		
mployer's Address:	Exteriorable reservoir na ladou	m Janellems you but sa	Bus. Phone:	D:1	1.4
Number of Brothers: Siste	ers: Have the		office?	01	
Nearest Relative's Home or Work #	American American (PATIENT'S SOCIA	AL SECURITY #		
Family Dentist:	into Yourfold	Referring Dentist o		1.7	
,	EMAIL ADDRESS:	THING IS SHARROW		F)	
NSURANCE INFORMATION -	EMAIL ADDITION	TROOP HALLANDS SHOW	um I ran (Es alnra		
Name of Dental Insurance - Primary	Name of Policyholder	- 21-211-215	Date of Birth	27	
Employer	Policy #	Group #			
Additional Dental Insurance - Secondary	Name of Policyholder	PAST	Date of Birth		
Effective Date Certificate	Policy #	Group #		10.00	
Name of Medical Insurance	Name of Policyholder	THE SCHOOL WILDOWS IN	Water in year man	07	
	Certificate #	Policy #	Group #	-	ow to
Effective Date	Certificate #	1,			
		H tradride will be read on	va little desperation		
Effective Date NSURANCE AUTHORIZATION AND A hereby authorize Dr. Robert Harri my dependent's treatments and I I dependents. I understand that I am res	ASSIGNMENT ison D.M.D., M.S.D. to furn hereby assign to the denti sponsible for any amount not o	ish information to st all payments fo covered by insurance	insurance ca or his services e.		
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hereby authorize Dr. Robert Harring dependent's treatments and I I dependents. I understand that I am result and expendents are supported by the second and dependents are considered. So any dental services can be rendered. Authorization is hereby granted for dependent. In an effort to reduce our billing costs so	ASSIGNMENT ison D.M.D., M.S.D. to furn hereby assign to the denti sponsible for any amount not of IGNATURE nes necessary that a signed per lental treatment. I will be res	ish information to st all payments for covered by insurance ermission is obtained ponsible for any bill town, we require that	insurance ca or his services ee. d from a parent of the control on the call fees or estimates	render or guard is child	red to r

2. If a sedative appointment is cancelled without 24 hour notice or if the appointment is broken, a \$50.00 charge will be made for each patient.

1. We require 24 hour notices of a cancellation of appointments. If no notice is given a \$25.00 charge will be made for each

3. As of age 15, most patients will be referred to a general dentist.

patient.



PAST MEDICAL HISTORY



YES		NO	-		world in state		ample Stopper
()		()	1.	Does your child see a physician for routine physical examination?		THE REAL PROPERTY.
					Date of last physical exam?		
()		()	2.	Has your child ever had a health problem?		7.1
()		()	3.	Has your child ever been under the care of a physician?		Amail Smart
()		() -	4.	Has your child ever been a patient in a hospital?		Responsible Persons Address
()		()	5.	Has your child ever been treated in an emergency room?		
()		()	6.	Has your child ever been allergic to anything? List		
()		()	7.	Has your child ever taken any medicines? List		Banglayar's Address
()		()	8.	Has your child ever had an unfavorable reaction to any medicine? List		Melhuri Employer
t 3	, S		1	9.	Has your child ever had any emotional, mental or nervous disorders?		W 565
1		,		10.	Plane short if you shill be a had mathless with any of the fall with		
				10.	() heart disease () diabetes () liver	1) hearing
					() heart murmur () asthma () cleft lip/palate	() epilepsy/convulsions
					() bleeding () anemia () kidney	() other physical/mental problems
				11.	What grade is your child in? School c	hild at	tends:
				12.	Were there any problems at birth?		is the second of the second
				13.	Date of Last Tetanus Immunization:		Oletine and the committee of the committee of
				14.	Child's Physician:		FIGHTAINTO IN EDWARTOON
				15.			Assessed - NEW MANAGE WILLIAMS BY BELIEVE
				10.	ac Bagali , Basisii		Threshouse
							The state
					PAST DENTAL HISTORY		Apditional Dental Insurance - Descridary
YES		NO	ri.		What is your main concern about your child's dental health?		es aramer saladires arment
/ E3		140	`	17.	Has your child ever been to the dentist? If yes, date of last exam:		
<i>i</i>		,	,	18.	Will your child be an unacongrative nationt?	ea di	INSURANCE AUTHORIZATION AN
ein,	ân	èqi	,61		Has your child ever sucked his fingers or thumb?	30.0	How long?
) an	t br			19.	Has your child inherited any family dental characteristics?	b w	How long?
1 3	177	6		20.		9700	the statement of the section and section a
()	77	()	21.	Does your water have fluoride in it?	DIB.	Cara
() .	()	22.		7-	
(1	(),		and the same of th		
()	e L	()	24.	Was your child breast fed? Is yes, at what age was it completely stopped?		envibrier ed riso aspivine (Streib vrij
				25.	Please check if your child has had problems with any of the following:		Authorization is hareby granted to
					() cavities () teeth sensitive to hot or cold () toothache () gum infection		() crooked teeth
	UV				() toothache () gum infection () teeth sensitive to sweets () teeth bumped	THE RE	() color of teeth () other dental problems
					/ / total sample		, other dental problems
φ.	3		Voc				I will be paying roday by:
Con	nmer	nts:			- HUSAKAMAD U		- H0108
							OFFICE POLICIES
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