

## ROBERT HARRISON, D.M.D., M.S.D. 700 McCarthy Boulevard, New Bern, NC 28562 252-633-0424 • Fax:252-638-6662 info@coastalpediatricdentistry.com www.drbobh.com

Patient Name: Nickname: Date of Birth: Age: \_ Mailing Address: City/State/Zip: Home Phone: City/State/Zip: Street Address: Cell Phone: Parents' Names: Who is responsible for payment of this account? Responsible Person's Address Home Phone: (If divorced or separated): Father's Employer: **SOCIAL SEC. #** Employer's Address: Bus. Phone: Mother's Employer: SOCIAL SEC. #\_ Bus. Phone: Employer's Address: Have they been a patient in this office? Number of Brothers: Sisters: Name & Address of Nearest Relative: Nearest Relative's Home or Work #\_ PATIENT'S SOCIAL SECURITY #: Family Dentist: Referring Dentist or Doctor: **EMAIL ADDRESS:** INSURANCE INFORMATION Name of Dental Insurance - Primary Name of Policyholder Date of Birth **Employer** Policy # Group # Additional Dental Insurance - Secondary Name of Policyholder Date of Birth Effective Date Certificate Policy # Group # Name of Medical Insurance Name of Policyholder Certificate # Policy # **Effective Date** Group # INSURANCE AUTHORIZATION AND ASSIGNMENT I hereby authorize Dr. Robert Harrison D.M.D., M.S.D. to furnish information to insurance carriers concerning my dependent's treatments and I hereby assign to the dentist all payments for his services rendered to my dependents. I understand that I am responsible for any amount not covered by insurance. **SIGNATURE** DATE Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any dental services can be rendered. Authorization is hereby granted for dental treatment. I will be responsible for any bill incurred on this child for dental treatment. In an effort to reduce our billing costs so that we can keep your fees down, we require that all fees or estimated co-payments be made on the day of the appointment. I will be paying today by: CREDIT CARD ☐ CASH ☐ CHECK ☐ CARECREDIT ☐ MEDICAID SIGNATURE (Parent or Guardian)

## OFFICE POLICIES

- 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 patient.
- 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.

## PAST MEDICAL HISTORY



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		Date of last physical exam?	
) ()	2.	ation in the second sec	ssenBbA (eet)
) ()	3.	Has your child ever been under the care of a physician?	arents' Nemes:
1 ( )	4.	Has your child ever been a patient in a hospital?	
1 ( )	5.	Has your child ever been treated in an emergency room?	
1 ( )	6.	Has your child ever been allergic to anything? List	18/0/0/0/12 8 19/0/0/12
		Has your child ever taken any medicines? List	mployer's Address:
) ( )	7.	Has your child ever taken any medicines: List	Inthode Employer
) ( )	8.	Has your child ever had an unfavorable reaction to any medicine? List	,
) ( )	9.	Has your child ever had any emotional, mental or nervous disorders?	mployer's Address:
	10.	Please check if your child has had problems with any of the following:	umber of Brothers:
		( ) heart disease ( ) diabetes ( ) liver (	) hearing
		( ) heart murmur ( ) asthma ( ) cleft lip/palate (	) epilepsy/convulsions
		( ) bleeding Apple ( ) kidney (	) other physical/mental problems
	11.	What grade is your child in? School child at	tenas:
	12.	Were there any problems at birth?	
	13.	Date of Last Tetanus Immunization:	MEURANCE INFORMATION
	14.	Child's Physician:	Verner of pendal friendings - Primary
	15.	Current Daily Medications:	
		Polley # . Group #	mployer
		PAST DENTAL HISTORY	dditional Dental Insurance - Secondary
	16.	What is your main concern about your child's dental health?	BOURDER TRACKS IN THE SECOND OF
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