WELCOME TO OUR PRACTICE

Mark H. Goldenberg, D.D.S., M.S. & Darrin J. Hirt, D.D.S., M.S.

416 No. Bedford Drive, Suite 101, Beverly Hills, CA 90210 (310) 271-5231

Date__________________

Patient and Family Information

Child's Name____
First Middle Last

Birthdate_________/_________/_________ ☐Male ☐Female

Home Address____

City____State___________Zip_____________

Home Phone (______)______________________________

Responsible Party____

Relationship to Child____

Name of Parent/Guardian_________________________________Birthdate______/_____/_____

Social Sec.#______________Home Phone (____)____________Cell Phone(____)___________

Occupation________________Employer___________________Bus. Phone (____)__________

Business Address_______________________________________E-mail____________________

City____State___________Zip______________

Name of Parent/Guardian_________________________________Birthdate______/_____/_____

Social Sec.#______________Home Phone (____)_____________ Cell Phone(____)___________

Occupation_________________Employer___________________Bus. Phone(____)___________

Business Address_______________________________________E-mail____________________

City____State___________Zip_______________

Referred By______________________________________

Child's Health History

	Yes	No		Yes	No		Yes	No
Allergies__________	☐	☐	Epilepsy	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	HIV/AIDS	☐	☐	Tonsillitis	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Hepatitis-Type____	☐	☐	Other_____________	☐	☐
Diabetes	☐	☐	Rheumatic Fever	☐	☐	_____________		

✳PLEASE COMPLETE REVERSE SIDE✳

Child's Physician ________________________________Phone (____)_____________

	Yes	No
1. Is your child taking any medications?	☐	☐

Please describe:____

2. Has your child ever had an allergic reaction to the following:

Local Anesthetics …………………………	☐	☐
Penicillin or other Antibiotics. ……………	☐	☐
Sulfa Drugs ………………………………..	☐	☐
Latex ……………………………. ………..	☐	☐
Other (Please list)…………………………..	☐	☐

Primary Dental Insurance

Person Responsible for Account____
Relationship to Patient____________________________Birthdate______/_____/______
Social Security #________________________
Employer_____________________________
Insurance Company____
Subscriber I.D.#________________________Group #______________________________

Additional Insurance

Person Responsible for Account____
Relationship to Patient____________________________Birthdate______/_____/______
Social Security #________________________
Employer_____________________________
Insurance Company____
Subscriber I.D.#________________________Group #______________________________

Emergency Contact________________________ Phone (____)_____________________

Assignment and Release

I hereby authorize payment directly to Drs. Mark H. Goldenberg and Darrin J. Hirt for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangement are satisfied.

I authorize the above doctors and /or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I hereby authorize the necessary dental treatment for _____________________________
Patient's Name

Signature of Responsible Party________________________________Date___________