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) 807-6144

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 THE NEXT PAGE✳

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_____