

Responsible Party Parent/Guardian

Father/Guardian Full Name

Address

City State Zip

SS# Birth Date

Home Phone # Business Phone #

Cell Phone # Email Address

Employer Occupation

Mother/Guardian Full Name

Address

City State Zip

SS# Birth Date

Home Phone # Business Phone #

Cell Phone # Email Address

Employer Occupation

Is patient living with both parents? Yes No

If no, with whom does the child reside? _____

Siblings

Name Birth Date

Name Birth Date

Name Birth Date

Nearest Relative/Friend

Name

Address

Phone

Relationship



Pediatric Dentistry by
Dr. Sheryl Radin
Dr. Ross Levine

808 Floral Vale Boulevard
Yardley, PA 19067
(215) 860-9808
www.growingsmilespa.com

Dental Insurance Information

Primary Dental Insurance Group #

Policy Holder Name

Secondary Dental Insurance Group #

Policy Holder Name

Consent for Treatment

I am the (parent/guardian) of _____
(name of child) who is a minor child, and I authorize
examination and treatment as necessary by or under the
supervision of Dr. Sheryl Radin and Dr. Ross Levine. This
includes exposure of radiographs as necessary, use of local
anesthesia, inhalation and oral medication, responsible restraint
as needed and use of appropriate medicaments and materials
for such treatment. If I have any objections to certain aspects of
treatment, I have stated so in the space provided below. I will
assume responsibility for fees associated with those procedures
for my child.

Parent/Guardian Signature

Date

PLEASE NOTE: Payment is expected for service rendered
at the time of treatment. If the family is not living together the
parent bringing the child is responsible for the child's account.

School Information

Name of Preschool or Elementary School your child attends or
will attend: