Lawrence A. Kotlow, DDS, P.C.

Patient Legal Guardian Information Form

Child's Name_____DOB_____.

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Legal Guardian (s):

Mother:_____Father:_____.

Other:_____Relationship:_____.

CIRCLE ONE: Single Married Separated Divorced Widowed Partnered

DO YOU HAVE JOINT CUSTODY? Yes No

Additional Guardian Authorization

I authorize_____to bring my child/children to their dental appointments.

Signed:_____Date:_____.

I authorize_____to obtain information on my child/children's account.
(If someone other than legal guardian)

Signed:_____Date:_____.

I authorize Dr. Kotlow to send reminders for dental treatment and confirm appointments by either telephone or post cards.

Signed:_____Date:_____.

I have read and understand the Privacy Practice information. I also authorize my child's name to appear on the sign in display monitor.

Signed:_____Date:_____.

LAWRENCE A. KOTLOW, DDS 340 FULLER ROAD ALBANY,NY 12203

PATIENT'S NAME(S):

_____DOB_____

MOTHER'S NAME_____DOB_____SS#_____

* ADDRESS_____CITY_____ST____ZIP_____

* HOME PH._____BUS PH._____*CELL PH_____ ___

* E-MAIL ADDRESS _____

FATHER'S NAME_____DOB_____SS#__ _____

ADDRESS_____CITY_____ST____ZIP_____

HOME PH._____ BUS.PH_____CELL PH._____

DENTAL INFORMATION:_____

PRIMARY

EMPLOYER_____INSURANCE CO. _____

EMPLOYEE_____SS#_____

RELATIONSHIP TO PATIENT_____

SECONDARY:

EMPLOYER_____INSURANCE CO._____

EMPLOYEE_____SS#_____

RELATIONSHIP TO PATIENT_____

PLEASE READ AND SIGN

REMEMBER THAT YOU ARE RESPONSIBLE FOR KEEPING US INFORMED OF ANY CHANGES IN YOUR CHILD'S INFORMATION.

I UNDERSTAND THAT I AM ALSO RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED

AS OF MARCH 27,2015, NEW YORK STATE REQUIRES ALL PRESCRIPTIONS TO BE SENT ELECTRONICALLY. THEREFORE YOU NEED TO PROVIDE THE NAME AND PHONE NUMBER OF YOUR PHARMACY

._____

SIGNATURE OF PARENT OR GUARDIAN_____

DATE_____

MAY WE SEND YOU A TEXT MESSAGE TO EVALUATE OUR OFFICE ?

PLEASE CIRCLE. YES NO