





# Twinkle Little Star<sup>TM</sup> Pediatric Dentistry

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NJ Pediatric Dental Specialty # 06080  
259 Kinderkamack Road  
Westwood, NJ 07675  
(201) 358-0800

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work phone \_\_\_\_\_

Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D.# \_\_\_\_\_

How much is your deductible \_\_\_\_\_ How much have you used \_\_\_\_\_ Max annual benefit \_\_\_\_\_

Do you have any additional insurance  Yes  No If yes, complete the following:

Name of insured \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work phone \_\_\_\_\_

Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D. # \_\_\_\_\_

Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible \_\_\_\_\_ How much have you used \_\_\_\_\_ Max annual benefit \_\_\_\_\_

## Consent

1. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
2. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
3. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.  
\_\_\_\_\_

4. My consent to disclosure of records shall be effective until I revoke it in writing.
5. I authorize payment directly to Twinkle Little Star Pediatric Dentistry, LLC or the dentist of insurance benefits, otherwise payable to me.
6. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts.
7. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.
8. I have read, understand and agree to abide by the Office Policies of Twinkle Little Star Pediatric Dentistry, LLC.
9. I attest to the accuracy of the information on this page.

**X** \_\_\_\_\_  
Signature of patient (or parent, if minor)

\_\_\_\_\_  
Date

Print Name (or parent, if minor): \_\_\_\_\_

“Helping your child’s teeth sparkle,  
one smile at a time.”