



PEDIATRIC DENTISTRY

Dear Valued Patient:

We are pleased to welcome you and your family to our practice, and appreciate the opportunity to provide your child/children with quality pediatric dental services. Our practice will grow as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time to express any concerns or to ask any questions that you may have to Dr. Hussain, Dr. Malhotra or our Staff. The information that follows is designed to answer many questions most patients have.

If an emergency arises outside of normal business hours, our answering service is available to contact the Doctor, and we will do our best to respond to your problem promptly.

We see all patients on an appointment basis and request that you call in advance so that we can reserve time for your child. We make every effort to honor all time commitments and request you extend the same courtesy to us.

If you are unable to make the appointment you have scheduled with us, please notify us at least **24 hours in advance**, otherwise a \$50.00 cancellation fee will be assessed. This courtesy makes it possible for us to give your appointment to another patient.

We hope that you share in our belief that regular preventative care is a sound investment. The responsibility for having your child return for this treatment rests primarily with you. We will schedule your child's next maintenance visit at the time of their last treatment appointment. Please keep in mind, we have a conservative approach on dentistry and make every effort to keep down the costs of your child's dental care.

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Please remember, in most cases insurance is considered for partial method of payment to the Doctor and copays are the responsibility of the patient. All payments are expected at the time of each visit, unless other financial arrangements have been made with our Practice Manager, Wanda. For your convenience, we accept all major credit cards, cash and care credit.

If your child has any medical problems, please make us aware before their scheduled appointment.

Once again, we welcome you as our patient!

Bitesize Pediatric Dentistry and Staff

I agree to be responsible for all my dental services, and understand that payment is expected at the time of each visit. In case of default, I agree to pay any interest, collection cost, and attorney fees incurred to collect this account.

I hereby authorize the release of all information from my records to my insurance company, which may be required for reimbursement of benefits to which I may be entitled under the provision of my policy.

_____/_____/_____
Signed (Patient/Guardian) Date

_____/_____/_____
Signed (Patient/Guardian) Date

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