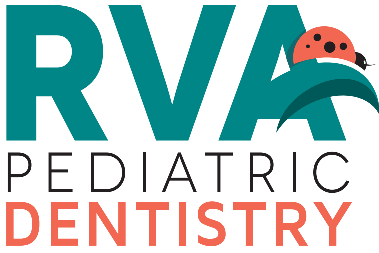


PLEASE TELL US A LITTLE INFORMATION ABOUT YOUR CHILD...

CHILD'S LAST NAME: ______________________ FIRST NAME: ______________________ MI: _____

CHILD'S PREFERRED NAME: ______________________ ❏ Male ❏ Female ❏ Other__________ Birth Date: __________

SSN: ______________________ Race/Ethnicity: ______________________

Home Address: ______________________ City: ______________________ Zip Code: __________

Name of School: ______________________ Grade: __________

Pediatrician: ______________________ Office Phone: ______________________

Other Siblings (Names and Ages):

____

____

____

Who has legal custody of this child?: ______________________

PARENT OR LEGAL GUARDIAN'S CONTACT INFORMATION

Parent/Legal Guardian #I Last Name: ______________________ First Name: ______________________ MI: _____

Birth Date: __________ SSN: __________ Email: ______________________

Employer: ______________________ Wireless Phone: ______________________

Work Phone: ______________________ Home Phone: ______________________

Home Address: ______________________ City: ______________________ Zip Code: __________

Parent/Legal Guardian #2 Last Name: ______________________ First Name: ______________________ MI: _____

Birth Date: __________ SSN: __________ Email: ______________________

Employer: ______________________ Wireless Phone: ______________________

Work Phone: ______________________ Home Phone: ______________________

Home Address: ______________________ City: ______________________ Zip Code: __________

Whom may we thank for your referral? ______________________

What is the purpose of today's visit? ______________________

Is this your child's first dental visit? ❏ Yes ❏ No If no, please list date of last dental visit and (name of dentist)

____

Has your child ever had a serious/difficult encounter or problem with dental treatment? ❏ Yes ❏ No

If yes, please explain: ______________________

____

PLEASE TELL US ABOUT YOUR CHILD'S MEDICAL AND DENTAL HISTORY

Although dental personnel primarily treat the areas in and around your child's mouth, your child's mouth is a part of your child's entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Has your child ever been hospitalized or had an operation? ❑ No If yes, please explain: ______________________________

____

Has your child ever had a serious head or neck injury? ❑ No If yes, please explain: ______________________________

____

Is your child taking any medications, pills, or drugs? ❑ No If yes, please explain: ______________________________

____

Is your child on a special diet? ❑ No If yes, please explain: ______________________________

____

Is your child allergic to any of the following substances? ❑ No If yes, please check the appropriate box and explain below:

❑ Acrylic ❑ Codeine ❑ Metal ❑ Other ______________

❑ Aspirin ❑ Local anesthetics ❑ Penicillin ______________

Please explain known allergy (or allergies) in detail: ______________________________

____

DOES YOUR CHILD HAVE (OR HAD) ANY OF THE FOLLOWING CONDITIONS?

NO *YES* **ADHD**
NO *YES* **AIDS/HIV+**
NO *YES* **Anaphylaxis**
NO *YES* **Anemia**
NO *YES* **Angina**
NO *YES* **Artificial Heart Valve**
NO *YES* **Artificial Joint**
NO *YES* **Asperger's Syndrome**
NO *YES* **Asthma**
NO *YES* **Autism**
NO *YES* **Bleeding Disorders**
NO *YES* **Blood Transfusion**
NO *YES* **Bronchopulmonary Dysplasia**
NO *YES* **Bronchitis**
NO *YES* **Cancer**
NO *YES* **Cerebral Palsy**
NO *YES* **Chemotherapy and/or Radiation**
NO *YES* **Cleft Lip**
NO *YES* **Cleft Lip & Palate**
NO *YES* **Cleft Palate**
NO *YES* **Cold Sores and/or Fever Blisters**
NO *YES* **Congenital Heart Defect**
NO *YES* **Cognitive Disorder**
NO *YES* **Diabetes**
NO *YES* **Down Syndrome**
NO *YES* **Eczema**
NO *YES* **Emotional Disorders**
NO *YES* **Epilepsy/Seizure Disorder/Convulsions**
NO *YES* **Febrile Seizures**
NO *YES* **Feeding Tube**
NO *YES* **Food or Drug Allergies**
NO *YES* **Hearing Impairment**
NO *YES* **Heart Condition**
NO *YES* **Heart Murmur**
NO *YES* **Hemophilia**
NO *YES* **Hepatitis A**
NO *YES* **Hepatitis B or C**
NO *YES* **Herpes**
NO *YES* **Hypertension**
NO *YES* **Hypoglycemia**
NO *YES* **Irritable Bowel Syndrome**
NO *YES* **Kidney Disease**
NO *YES* **Leukemia**
NO *YES* **Liver Disease**
NO *YES* **Low Blood Pressure**
NO *YES* **Lung Disease**
NO *YES* **Migraine Headaches**
NO *YES* **Mitral Valve Prolapse**
NO *YES* **Mononucleosis**
NO *YES* **Mumps/Measles**
NO *YES* **Muscular Dystrophy**
NO *YES* **Panic Attacks**
NO *YES* **Pregnancy**
NO *YES* **Psychiatric Care**
NO *YES* **Renal Disease**
NO *YES* **Rheumatic Fever**
NO *YES* **Reflux**
NO *YES* **Scarlet Fever**
NO *YES* **Seasonal Allergies**
NO *YES* **Sickle Cell Disease**
NO *YES* **Sickle Cell Trait**
NO *YES* **Sinus Problems**
NO *YES* **Speech Impairment**
NO *YES* **Spina Bifida**
NO *YES* **Stomach/Intestinal Disease**
NO *YES* **TMJ Pain**
NO *YES* **Tonsilitis**
NO *YES* **Tuberculosis**
NO *YES* **Tumors/Growths**
NO *YES* **Ulcers**
NO *YES* **Urinary Tract Infection**
NO *YES* **Visual Impairment**

Has your child ever had any serious illness not listed above? ❑ No If yes, please explain: ______________________________

____

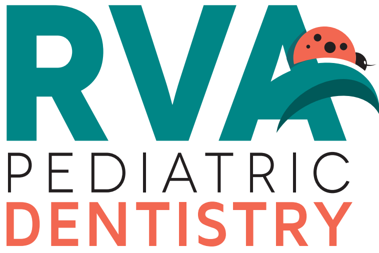
____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that withholding medical history information or providing incorrect or inaccurate information can be dangerous to the child's health.

It is my responsibility to inform the dental office of any changes in medical status.

PARENT/LEGAL GUARDIAN'S SIGNATURE ______________________________ DATE: ______________



DENTAL INSURANCE INFORMATION

We are happy to assist you in obtaining the maximum benefit from your dental insurance plan. Once your plan coverage has been identified, we will accept assignment of payment from your insurance company. Most plans cover a portion of the dental fee, which means you will be responsible for both your deductible and the portion we estimate that your plan will not cover. If your estimated portion is different than estimated, a statement or a refund will be mailed to you. Payment of your portion is expected before services are actually rendered. Please provide us with a copy of your insurance card. It is your sole responsibility to notify our business office of any changes in your insurance plan or policy. If your insurance company has not rendered payment within 45 days of the date of service, you will be billed in full for any outstanding balances.

Primary Dental Insurance: __________________________ Group #: ____________________________________Subscriber ID: _______________________

Insurance Company Address: ____Phone Number: _______________________

Name of Insured (Parent/LG): ____ Relationship to Patient: _______________________

Primary Dental Insurance: __________________________ Group #: ____________________________________Subscriber ID: _______________________

Insurance Company Address: ____Phone Number: _______________________

Name of Insured (Parent/LG): ____ Relationship to Patient: _______________________

Is your child covered under any of the Medicaid insurance programs? No ❑ Yes ❑ Patient's ID# Identifier: _________________________________

I certify the above information is correct and true to the best of my knowledge. I understand that providing incorrect information could be dangerous to my child's health. I authorize RVA Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to my child during such dental care to third party payors and/or health practitioners. I authorize and request my primary and/or secondary insurance company(s) to pay benefits directly to the dentist. I understand that my dental insurance carrier(s) may pay less than the actual bill for services. I consent to the treatment for this child. I understand RVA Pediatric Dentistry does not bill an absent parent and payment of any estimate payment is due at the time of treatment. I also agree to assume full financial responsibility for all treatment rendered and, if necessary, collection costs, attorney fees, and contingent fees to collection agencies of not less than 35% of your billed totals. Such contingency fee is added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via email or text message using any contact information that you provide. Methods of contact may include the use of prerecorded and artificial voice messages and/or use of an automated dialing device.

Signature of Parent ____ Date: _______________________
or Legal Guardian: (If patient is under the age of 18)

1. Any person eighteen (18) years or older and mentally competent, may sign their informed consents.
2. If a person is termed incompetent by the court system and a legal guardian has been appointed, the legal guardian will sign the consent forms. A copy of the court order granting legal guardianship must be obtained and placed into the legal, dental record.
3. Minors defined as seventeen (17) years of age and under will have their consents signed by their parent or legal guardian.
4. Minors whose parents have terminated their legal rights and another guardian has been appointed by the court system may have their informed consent signed by their guardian. A copy of the court order granting legal guardianship must be obtained and placed into the legal, dental record.
5. Minors who are wards of the state including pending adoptions may have their informed consent signed by social worker legally assigned to them by the court.
6. The social worker shall be through the Department of Human Resources. A copy of the court order granting legal authorization to the social worker will be placed with the legal, dental chart.
7. Any person signing informed consent for a person of legal age must have a copy of the Power of Attorney giving them permission to sign for them. A copy of this legal form must be placed in the legal dental chart.
8. Any person deemed to be a minor must be accompanied to each visit by a parent/guardian or authorized person. Any person other than the parent/guardian bringing said minor to an appointment must be listed below by the legal parent/guardian.

Please list any person/persons who have your permission to bring the patient to his or her appointment and make decisions regarding your child(ren's) dental treatment.

Name: ____ Relation: _______________________

Name: ____ Relation: _______________________

FINANCIAL AND INSURANCE POLICIES

I have received the RVA Pediatric Dentistry financial and insurance policy which outlines my financial responsibility toward care rendered by the doctors at RVA Pediatric Dentistry. ***I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered.***

Medical / Dental Release Statements

I give my consent for the doctors of RVA Pediatric Dentistry to complete a thorough examination on the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Furthermore, I understand that it is my responsibility to inform RVA Pediatric Dentistry of any future changes to my child's medical history status. As a parent or legal guardian of the previously named patient, I also hereby grant the doctors and staff of RVA Pediatric Dentistry permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

Insurance Claim Release & Financial Responsibility Statement

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my child's dental insurance company. I am aware that RVA Pediatric Dentistry will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

Authorization For Direct Payment

I hereby authorize payment of insurance benefits directly to RVA Pediatric Dentistry or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Notice Of Privacy Practices, Health Insurance Portability & Accountability Act Of 1996

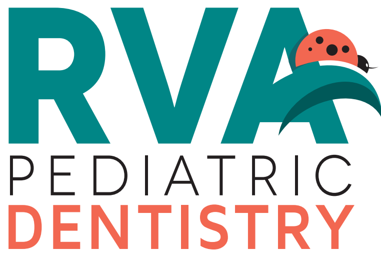
I have read the form entitled, "NOTICE OF PRIVACY PRACTICES," and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit RVA Pediatric Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

Appointment Cancellation Or No-Show Policy

Many patients are waiting months in advance for appointments. We respect our patient's time and book their appointment times accordingly. Additionally, in the event an appointment is missed without a 24 hour notice and/or the continuation of missed appointments without notice we reserve the right to dismiss the patient from RVA Pediatric Dentistry.

I have read and understand the above policies and will abide by them.

Parent Signature:____ Date: __________________________



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of- pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated.
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Contact at RVA:
- We will never market or sell your personal information.