Centreville Children's Dentistry

. . . Where every child is special

14245-M Centreville Square
Centreville, VA 20121
(703) 266-9090
www. CentrevilleChildrensDentistry.com

We would like to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions, we will be happy to assist you. We look forward to working with you and your child to ensure a future of optimal oral health.

Today's Date: _____/____/20____

1. Patient's Information

Child's Name ____ Nickname (if any) ______________________
Last First MI

Date of Birth ____/_____/_____ Age ____ Sex: M F School ____ Grade________

Home Address ____City ________________________ State_____ Zip ___________

Name and Age of Siblings ____

Interests or Hobbies ____

Parent's Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Whom May We Thank for Referring You? ____

2. Mother's Information

Name____ [ ] Stepmother [ ] Guardian Birthdate ____/______/______
Last First MI

Social Security # ______________________ Home phone # _____________________________ Cell # ______________________________

Home Address ____City ________________________ State_____ Zip ___________

Employer ____ Occupation ___________________ Work Phone # ____________________

Business Address ______________________________________City ________________________ State _____Zip___________

Active Duty Military at this time? [ ] Yes [ ] No Email address: ____

3. Father's Information

Name____ [ ] Stepfather [ ] Guardian Birthdate ____/______/______
Last First MI

Social Security # ______________________ Home phone # _____________________________ Cell # ______________________________

Home Address ____City ________________________ State_____ Zip ___________

Employer ____ Occupation ___________________ Work Phone # ____________________

Business Address ______________________________________City ________________________ State _____Zip___________

Active Duty Military at this time? [ ] Yes [ ] No Email address: ____

4. Who is Accompanying the Child Today?

Name ____ Relationship ____________________________________

Do you have legal custody of this child? [ ] Yes [ ] No

5. Person Responsible for Account

Name ____

Billing Address ____City ________________________ State_____ Zip ___________

**** You MUST provide a physical address! P.O. Boxes are not acceptable.**

Home Phone # ____ Work Phone # ____

6. Insurance Company Information

	Primary Dental Insurance	Secondary Dental Insurance (if applicable)
Name of Insurance Company		
Insurance Company Phone #		
Employee ID #		
Group #		
Policy Owner's Name		
Relationship to Patient		
Policy Owner's Birthdate		
Social Security #		
Policy Owner's Employer		

7. Dental History

Why did you make this appointment? ____

Is this your child's first visit to the dentist? [ ] Yes [ ] No If not, how long since the last dental visit? ____________________

Child's previous dentist ____________________ Address ____________________ Phone ____________

Approximate date of last x-rays ________________ Has your child had an unpleasant dental experience? [ ] Yes [ ] No

Does your child have any of these habits? [Bottle] [Pacifier] [Thumb/Finger Habit] [Tongue Thrust] [Lip Sucking/Biting] [Mouth Breathing] [Grinding]

Does your child brush his/her own teeth? [Yes] [No] How frequently, and when? ____________________

Do you help your child brush his/her teeth? [Yes] [No] How frequently, and when? ____________________

Do you or your child use dental floss in cleaning your child's teeth? [Yes] [No] How frequently, and when? ____________________

Has your child had fluoride in any of the following forms? [Tablets] [Drinking water] Toothpaste Brand ____________________

Have your child's teeth ever been injured? [Yes] [No] When? ____________ How? ____________________

Were the teeth treated? [Yes] [No] If yes, describe the treatment ____________________

Does your child complain of clicking, popping, or crunching noises in his/her ears while chewing? [ ] Yes [ ] No

8. Health History

Child's Physician ____________________ Phone # (____)____________ Date of last physical exam ____/___/________

Is the child under the care of a physician? [Yes] [No] Ever been hospitalized? [Yes] [No] Ever had surgery? [Yes] [No] Blood Transfusions? [Yes] [No]

Does your child take Birth Control Pills? [Yes] [No] Is your child pregnant? [Yes] [No]

Does your child have any allergies? [Yes] [No] If yes, please list: ____________________

Is your child taking any medications at this time? (including over-the-counter medications, vitamins, herbal supplements) . . . .[Yes] [No]

Medication	Dose	Frequency	Reason

Does your child have any history of the following diseases or conditions?

- ☐ Accidents or Severe Infections
- ☐ Allergies
- ☐ Anemia or Blood Disorders
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart Valves
- ☐ Asthma or Lung Problems
- ☐ Attention Deficit / Hyperactivity
- ☐ Autism
- ☐ Anaphylaxis
- ☐ Bleeding Problems/ Hemophilia
- ☐ Cancer / Tumors
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Cleft lip/palate
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Fainting, Convulsion, Seizures, or Epilepsy
- ☐ Headaches
- ☐ Heart Murmur, Congenital Heart Disease/ Mitral Value Prolapse
- ☐ High/Low Blood Pressure
- ☐ HIV / AIDS / ARC
- ☐ Kidney or Bladder Problems
- ☐ Latex Sensitivity
- ☐ Liver problems, Jaundice, or Hepatitis
- ☐ Mental Retardation
- ☐ Other – Please explain
- ☐ Psychiatric Problems
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Speech, Learning, or Hearing Disorder
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Thyroid Disease or Malfunction
- ☐ Tonsillitis
- ☐ Tuberculosis TB
- ☐ Vision Problem

9. Authorization

I understand that the information I have given is correct and to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changed in my child's medical status. I am the parent, guardian, or personal representation of the child listed above. There are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I certify that my dependent is covered by the insurance listed above and assign directly to Centreville Children's Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance company to pay to the dentist (or dental group) all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Centreville Children's Dentistry may use my child's health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining benefits of the benefits payable for related services. Your child's appointment is reserved for him/her. No charge will be made of rescheduling an appointment providing 48 hours (business hours) notice is given.

Signature ____ Relationship _____________________________ Date _____________________

Doctor's Signature ____ Date _______________________

Summary: (For Doctor's Use)

MEDICAL:

DENTAL:

CENTREVILLE CHILDREN'S DENTISTRY

Patient Name: ____ Date of Birth: ______________________________

Thank you for choosing our practice for your child's dental care. We are committed to providing the best quality dental care possible and the best service possible. The following is a statement of our Financial Policy. Please read and sign it prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
FULL PAYMENT OF INSURANCE DEDUCTIBLE AND COPAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND DISCOVER.

REGARDING INSURANCE

Your claims are submitted as a courtesy by our office. Your dental insurance policy is an agreement between you and your insurance company. Please be aware that some, perhaps all, of the services provided may be *non-covered* services, and therefore, are your responsibility. If your insurance company has not paid your claim within 45 days, the balance will automatically be billed to you. **You, and not your insurance company, are responsible for your account. You are expected to pay your estimated portion at the time of service.** Any balance will be billed to you, and payment is expected within 30 days. If your insurance company does not pay our bill for any reason, you are responsible for the full payment. In the event of an account overpayment, the difference will be refunded to you.

Appointment Information

Appointments are the responsibility of the patient. Our practice provides courtesy reminder calls two business days in advance of your child's scheduled appointment. If you cannot keep your scheduled appointment, we ask for at least 2 business days notice. A $25.00 fee will be charged for a failed appointment. If an appointment is longer than 60 minutes, a $50.00 deposit will be required to secure the appointment. This $50.00 will be applied to the services rendered. If the appointment is not kept and no notice is given, this $50.00 will not be refunded. Multiple failed appointments will result in discharge from our care. Any failed appointment on school holidays will result in a $50.00 charge per appointment.

Past Due Accounts

Accounts are considered past due after 30 days. Past due accounts will be charged a Rebilling/Finance Charge for $5.00 per month. Checks returned by your bank will be subject to a return check fee. Accounts turned over to our collection agency or attorney, and sent to court, will be subject to reasonable attorney's fees and court costs.

I have read, understand, and agree to this Financial Policy.

Parent/Guardian ______________________________ Date ___________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.
- I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*
- I understand that I may request in writing that you restrict how much private information is used, or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____ Date:______________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices*, but was unable to do so as documented below.

Date:	Initials:	Reason:

Statement of Privacy Practices

This is your copy

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Our office is dedicated to protect the rights of our patients and the confidential information entrusted in us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties of it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will never use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, electronic mail, world wide web, and postal mail.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in many formats; and to request a list of instances in which we, or our businesses associates, have disclosed your protected information for used other than state above. All such request must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately so that we may take appropriate action.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.