



Richmond Pediatric Dentistry and Orthodontics

(804)741-2226
www.RPDO.com

2560 Gaskins Road, Richmond, VA 23238
7521 Right Flank Road, Suite 110, Mechanicsville, VA 23116

Carl O. Atkins, Jr., D.D.S.
Christopher L. Maestrello, D.D.S.
Elizabeth C. Miller, D.D.S.
Raymonia A. Eddleton, D.D.S.
Rebecca T. Wehman, D.D.S.
Reham M. AlNajjar, D.D.S.

CHILD'S INFORMATION AND HEALTH HISTORY

INITIAL EXAM _____ DATE _____

CHILD'S FULL NAME _____ DATE OF BIRTH _____

(Name Child Prefers)

CHILD'S ADDRESS _____ HOME PHONE(____) _____

CITY _____ STATE _____ ZIP CODE _____ PREFERRED PHONE(____) _____

HOBBIES AND INTERESTS _____ GENDER M / F

BROTHERS AND SISTERS NAMES _____

PARENT (Guardian) NAME _____ Relation to Patient _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE(____) _____

DATE OF BIRTH _____ S.S# _____ CELL PHONE (____) _____

EMPLOYED BY _____ DEPARTMENT _____

EMAIL ADDRESS _____ BUSINESS PHONE(____) _____

PARENT (Guardian) NAME _____ Relation to Patient _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE(____) _____

DATE OF BIRTH _____ S.S# _____ CELL PHONE (____) _____

EMPLOYED BY _____ DEPARTMENT _____

EMAIL ADDRESS _____ BUSINESS PHONE(____) _____

NAME OF FRIEND OR NEIGHBOR WHO CAN REACH YOU IN CASE OF EMERGENCY _____

HOME NUMBER (____) _____ CELL PHONE (____) _____

DENTAL INSURANCE PLAN (IF ANY) _____ SUBSCRIBER NAME _____

POLICY# _____ GROUP# _____

HOW DID YOU HEAR ABOUT US?

- | | | |
|--|--|--|
| <input type="checkbox"/> Pediatrician _____ | <input type="checkbox"/> Insurance Carrier _____ | <input type="checkbox"/> Family/Friend _____ |
| <input type="checkbox"/> Dentist _____ | <input type="checkbox"/> Advertisement _____ | <input type="checkbox"/> Website _____ |
| <input type="checkbox"/> Health Department _____ | <input type="checkbox"/> Internet _____ | <input type="checkbox"/> Other _____ |

Welcome! Please take a few moments to tell us a little about your child so that we may assist you in taking the very best care possible of him/her!

HEALTH HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST MEDICAL EXAM _____ CHILD'S AGE _____

PHYSICIAN'S PHONE NUMBER(____) _____

- | YES | NO | YES | NO | YES | NO |
|--|-----------------------|--|-----------------------|-----------------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Allergy to Penicillin | | Blood Transfusion | | Kidney Problems | |
| Allergies to Other Drugs | | Cancer | | Leukemia | |
| Allergies to Local Anesthetics | | Cerebral Palsy | | Liver Problems, Hepatitis | |
| Allergies to Latex, Metals or Acrylics | | Chemotherapy / Radiation | | Mental or Physical Handicap | |
| Heart Murmur, Defect or Surgery | | Child Abuse | | Premature Birth | |
| AIDS - HIV | | Developmentally Delayed | | Rheumatic Fever | |
| Anemia or Blood Problems | | Emotional Difficulties / Psychiatric Care | | Sickle Cell Anemia | |
| Asthma | | Extreme Nervousness or Apprehension | | Syndrome _____ | |
| Diabetes | | Eye Problems | | Thyroid disorders | |
| Epilepsy, Seizures, Convulsions | | Hay Fever, Sinus Problems, General Allergies | | Tonsilitis | |
| Autism | | Hearing / Speech Problems | | Tuberculosis | |
| Birth defects | | Hyperactivity (ADD/ADHD) | | Ulcer or colitis | |
| Bleeding problems : Hemophilia | | | | Other _____ | |

Medications _____

Hospitalizations: Age and Reason _____

DENTAL HISTORY

DOES YOUR CHILD HAVE ANY DENTAL PROBLEMS AT THIS TIME? _____

DATE OF LAST DENTAL EXAM _____ ANY UNFAVORABLE DENTAL EXPERIENCE, YES NO

PLEASE EXPLAIN _____

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- | | | |
|---|--|---|
| <input type="radio"/> Traumatic injury to mouth or teeth | <input type="radio"/> Pain around ear | <input type="radio"/> Frequency of brushing by child _____/day |
| <input type="radio"/> Bleeding gums, How long _____ | <input type="radio"/> Bad breath | <input type="radio"/> Frequency of brushing by parent _____/day |
| <input type="radio"/> Clenching or grinding of teeth | <input type="radio"/> Orthodontic treatment | <input type="radio"/> Dental floss |
| <input type="radio"/> Swelling or lumps in mouth | <input type="radio"/> Mouth breathing | <input type="radio"/> Fluoride supplements |
| <input type="radio"/> Frequent blisters on lips or mouth | <input type="radio"/> Oral habits; thumbsucking, fingernail biting, cheek biting, etc. | <input type="radio"/> Between meal snacks |
| <input type="radio"/> Teeth sensitive to cold, heat, sweets or pressure | | <input type="radio"/> Well balanced diet |

APPOINTMENTS: Please realize we have reserved time especially for your child. If for some reason you must cancel your child's appointment we expect 48 hours notice (weekends not included). A charge will be made for failed or cancelled appointments without 48 hours (weekends not included) notice. This fee covers only a portion of the expense associated with the time reserved for your child. Failure to comply with this policy may result in the dismissal of your family from the practice.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged to them and that they are personally responsible for payment of fees. As a courtesy to you we will prepare necessary forms or reports to help the persons responsible obtain benefits from insurance companies. Any questions concerning insurance benefits should be directed to the insurance company's representative or benefits office. The deductible and/ or co-payment is expected at the time of service. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

ACCOUNTS: All services are performed on the assumption that payment is expected at time of service. All account balances unpaid past 30 days will be credited with a monthly handling charge of 2% (annual percentage rate of 24%). In case it becomes necessary to seek collection resources due to default or late payment, all reasonable attorney's fees and other costs of collection will be in addition to the existing account balance.

CONSENT: Carl O. Atkins, Jr. D.D.S., Christopher L. Maestrello, D.D.S., Elizabeth C. Miller, D.D.S., Raymonia A. Eddleton, D.D.S., Rebecca T. Wehman, D.D.S., Reham M. AlNajjar, D.D.S., their associates and/or their staff are authorized to perform such dental and related surgical or medical treatments as deemed necessary and all risks and treatments will be explained as needed.

I have read the above and to the best of my knowledge the information is correct.

I have reviewed the treatment plan and fees. I Agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to my child's treatment.

I Hereby authorize payment of the dental benefits otherwise payable directly to Richmond Pediatric Dentistry and Orthodontics.

SIGNATURE _____ DATE _____
PARENT OR GUARDIAN

Office Policies

Recall Appointments

Broken appointments or short term cancellations (within 24 hours, weekends not included) without proper notification can be costly and unfair to other patients who need appointments. We try to remind patients by telephone prior to the appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to be present. If you are running late, please notify us. Arriving 15 minutes late or more is considered a broken appointment and may require rescheduling so that other patients are not kept waiting. Please be informed that **2 missed appointments will result in a \$25.00 charge for each patient**. This fee must be paid prior to scheduling any future appointments. Repeated broken appointment and short term cancellations may be subject to dismissal from the practice.

*During the school months, late afternoon appointments are in high demand. We try to honor after school requests and ask that you help us by understanding when we need to appoint during school hours. We will gladly provide you with a school excuse for your child.

Restorative Appointments

Conscious Oral Sedation & Nitrous Oxide (laughing gas) Appointments

As a courtesy, our office will attempt to contact you for confirmation before the appointment. However, we do ask that parents and/or guardians assume responsibility for their appointment time. Failure to provide our office with 2 business days notice (weekends not included) will result in a **\$50.00 charge per 15minutes of scheduled appointment time**. If the appointment is missed due to a sudden illness, a note from the child's doctor will suffice. Cancellation of all future appointments for your child and family members will be suspended until the broken appointment fee is paid in full.

****Some insurance companies will not allow a practice to charge a broken appointment fee for missed appointments. This results in the release of the family from our practice.**

If you have any questions about this policy, do not hesitate to ask any member of our staff, they will be glad to answer your questions. We believe that good communication is the key to excellence in dental care.

Patient/Responsible Party Signature

Date

Richmond Pediatric Dentistry & Orthodontics

Authorization for the Release and/or Discussion of Protected Health Information

Patient Name: _____ Birth Date: ___/___/___

Authorization

1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. Name of persons or organizations: _____

3. To release and/or discuss the following information

Complete Record Outpatient Care Inpatient Care
X-Ray Results Laboratory Results Treatment Plan Update
Other _____

4. Signature:

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires upon the following specified event:

_____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship _____ Date: ___/___/___

Richmond Pediatric Dentistry & Orthodontics
2560 Gaskins Road, Richmond VA 23238
Privacy Practice

It is the policy of our office that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will-

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in the conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TOP, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only within their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:
 - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have the right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has the right to inspect and obtain a copy of his/her PHI. Our practice and its physicians will:
 - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patient's appeals.
- All physicians and staff will maintain a list of all disclosures of PHI for purposes other than TOP for each patient. We will provide this list upon request in writing.
- All physicians and staff will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff must adhere to this policy. Our practice will not tolerate violations. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available upon request.