Richmond Pediatric Dentistry and Orthodontics

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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?

☐ Pediatrician_____ ☐ Insurance Carrier ☐ Family/Friend _____
☐ Dentist_____ ☐ Advertisement ☐ Website _____
☐ Health Department_____ ☐ Internet ☐ 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	
◯	◯	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 (√)

◯Traumatic injury to mouth or teeth
◯Bleeding gums, How long_____
◯Clenching or grinding of teeth
◯Swelling or lumps in mouth
◯Frequent blisters on lips or mouth
◯Teeth sensitive to cold, heat, sweets or pressure
◯Pain around ear
◯Bad breath
◯Orthodontic treatment
◯Mouth breathing
◯Oral habits; thumbsucking, fingernail biting, cheek biting, etc.
◯Frequency of brushing by child_____/day
◯Frequency of brushing by parent_____/day
◯Dental floss
◯Fluoride supplements
◯Between meal snacks
◯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: Christopher L. Maestrello, D.D.S., William O. Dahlke, D.M.D., Raymonia A. Eddleton, D.D.S., Jasmine Chopra, D.D.S., Sarah Yi, 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

RICHMOND PEDIATRIC DENTISTRY & ORTHODONTICS

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

Effective: July 20, 2009 Updated: September 16, 2019

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.

RICHMOND PEDIATRIC DENTISTRY & ORTHODONTICS

Richmond Pediatric Dentistry & Orthodontics
2560 Gaskins Road 804-741-2226 *(Office)*
Richmond, VA 23238 804-741-6751 *(Fax)*

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Printed Name_____

Signature_____

Date_____

Office use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (please specify)

_____

RICHMOND PEDIATRIC DENTISTRY & ORTHODONTICS

HIPAA Consent Form
Acknowledgement of Receipt of Privacy Practices

Patient Name _____

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Richmond Pediatric Dentistry and Orthodontics may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though we have always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice. Signing below indicated that you have read the Notice of Privacy Practices.

I hereby acknowledge that I have received a copy of Richmond Pediatric Dentistry and Orthodontics Notice of Privacy Practices. _____ (Initials of patient/guardian)

Medical Information may be shared, obtained, and exchanged verbally or in writing with:

_____
(Name/relationship)

_____
(Name/relationship)

_____
(Name/relationship)

Please list an emergency contact below in the event we are unable to reach you:
Name:_____ Phone Number:_____

All professional services rendered are charged to the patient's responsibility. All fees, regardless of insurance coverage, are the responsibility of the responsible party. I understand my signature authorizes releasing of the information to the insurer.

_____ _____
Signature of Patient/Guardian Date Signed