



Patient Information Form

Today's Date: ____/____/____

Patient's Name: _____ Preferred Name: _____

Street: _____ City: _____ State: ____ ZIP: _____

Mailing Address (if different from above): _____

Home Phone: _____ Date of Birth: ____/____/____ Gender: Male Female

School: _____ Grade: _____

Name of Person Bringing Patient to Appointment: _____

How are you related to this patient? _____ Do you have legal custody of this patient? Y or N

Cell Phone: _____ Work Phone: _____ Email: _____

Name of Emergency Contact: _____

Relationship to Patient: _____ Daytime Phone: _____

Do you have Dental Insurance? Y or N

Do you have Orthodontic Coverage? Y or N

Name of Insurance Company: _____

Full Name of Policy Holder: _____ Date of Birth: ____/____/____

Employer: _____ Policy Holder's Social Security #: ____-____-____

Address of Policy Holder (if different from patient): _____

Patient's/Parent's Chief Concern _____

Date of Last Dental Visit: _____ Reason for visit: _____

Whom may we thank for referring you? _____

Primary Care Physician: _____ Phone: _____

I will not hold Children's Dentistry & Orthodontics of Lynchburg or any member of their staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes later to the content on this form, I will so inform this practice.

Custodial Parent/Guardian Signature: _____ **Date:** _____



Financial Policy

We welcome your child and family into our practice and are committed to providing your child(ren) with the highest standard of dental care. Prior to your appointment we will provide you with a treatment plan that estimates the total fee for our services including what we anticipate your insurance to cover as well as your estimated out-of-pocket expenses. Please remember that this is only an estimate and that an additional bill or possibly a refund may be required once the claim has been paid. You are responsible for all balances due after thirty days.

Methods of Payment

We accept payment by cash, check, Visa, MasterCard or Discover. We can also offer information about a third-party lending institution.

Dental Insurance

Dental insurance is a contract between you, and/or your employer and your insurance company. We are not a party to that contract. Our recommendations for treatment are based on what will be best for your child and not what your insurance may or may not pay. If you have any concerns about your coverage, please contact your employer or your insurance company.

Dental insurance typically does NOT cover all fees. Most plans routinely pay between 50-75% of the average total fee for a procedure. The percentage your plan pays is determined by how much you or your employer has chosen to pay for dental coverage. Many insurance companies do not pay the difference between white fillings (composites) and silver fillings (amalgams). You are responsible for any difference in cost, since composites are more expensive to place.

Though we are not obligated to do so, we will file your insurance claim as a courtesy to you. **Any amount estimated not to be covered by your insurance company is payable at the time services are rendered.** Please remember this is only an ESTIMATE and not a guarantee of what your insurance will pay. You may owe more once the claim has been paid by your insurance. If your insurance pays more than we estimated, we will send you a refund.

We allow a maximum of 45 days for insurance reimbursement. After this period, any amount unpaid by your insurance company is due in full, by you, within 30 days.

Because your dental insurance is a contract between, you, your employer and the insurance company, some carriers will only send reimbursement to you, not our office. It is your responsibility to notify us immediately if your insurance company has sent our payment to you. We reserve the right to require payment in full on day of service if we find that the insurance company repeatedly sends our reimbursement to you.

The insurance carriers are billed electronically after each visit, unless the company specifies paper statements. It is your responsibility to supply this office with necessary forms to complete the billing if needed.

We reserve the right to stop filing your insurance if at any time there is a problem with your account because of your insurance company, or your unwillingness to cooperate.

If you discontinue care for any reason, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company.

Signature of Responsible Party

Date



Consent for Disclosure of Protected Health Information (HIPAA)

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____ **Date of Birth:** _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information or my child's protected health information as described in the "Notice of Privacy Practices."

Signature: _____ **Date:** _____

Relationship to Patient: _____

Other person(s) to whom you give permission to discuss health information:

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This notice takes effect 11-17-2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Unless you give us additional written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.



Notice of Privacy Practices *(continued)*

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications to third parties without your written authorization.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcard, or letters).

PATIENT RIGHTS

Access: You have the right to review or receive copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 17, 2008. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.



Notice of Privacy Practices *(continued)*

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information: **Office Manager**
Children's Dentistry and Orthodontics of Lynchburg
105 Paulette Circle
Lynchburg, VA 24502
Tel. (434) 237-0125



Office Policies

We commit to providing quality, compassionate and professional care to your child(ren). It is our goal to provide the highest level of care to all children regardless of race, religion, sex, national origin, disability or insurance status. In order to maintain these standards, the following policies are in place to maintain the integrity of our interactions with you and your family. Please understand it is our desire to serve your needs to the best of our abilities and we need your assistance in developing a harmonious relationship.

Please be aware that **24-HOUR NOTICE** is required if you need to reschedule an appointment. If your child or children miss or reschedule less than twenty-four hours prior to **ONE SEDATION, ONE EMERGENCY EXAM, ONE HOSPITAL VISIT OR TWO APPOINTMENTS OF ANOTHER TYPE**, we will not reschedule your child or children for additional appointments. Your child or children will no longer be considered patients of record. This policy is enforced if the missed appointments are the same day or different days. Repeated reschedules will be treated as missed appointments and the same policies will apply. **If your phone number changes and we are not able to reach you to reconfirm an appointment, YOUR APPOINTMENT WILL BE CONSIDERED CANCELLED.**

IF YOU FAIL YOUR FIRST APPOINTMENT WITHOUT NOTIFYING OUR OFFICE AT ALL YOU WILL BE INACTIVATED, AND WILL NOT BE GIVEN ANOTHER APPOINTMENT.

It is very important that children maintain periodic dental visits. Dental disease progresses very rapidly in primary teeth. Failure to maintain consistent care puts your child at risk for dental emergencies and periodic examinations are vital to staying healthy. **Missed appointments and/or untimely scheduling will cause your child to be inactivated as a patient in this practice. Inactivated patients will not be reactivated.**

This practice will submit insurance claims on your behalf as a courtesy. We allow a maximum of 45 days for insurance reimbursement. After this period, you will be responsible for any unpaid portions in full. We do our best to coordinate your benefits with amount owed, but all quoted estimates are not guarantees of insurance payment. If you have any concerns of what you may owe, it is your responsibility to verify coverage for any procedure planned. Many insurance companies do not pay the difference between white fillings (composites) and silver fillings (amalgams). You are responsible for any difference in cost, since composites are more expensive to place. Please contact your insurance company if you have questions regarding their payment policies.

There will be a \$35.00 returned check fee for all personal checks returned for insufficient funds.

After attempts to collect outstanding funds and a 90-day grace period from time of service, parents/guardians not fulfilling their financial obligation will be sent to collections. Overdue accounts greater than thirty days will be subject to all collections charges, interest fees (compounded monthly at 6%), legal fees, and any court costs associated with recovering funds due. You will also be prosecuted criminally by the City of Lynchburg. Overdue accounts will no longer be considered patients of record.

If an employee of the practice is accidentally contaminated with your child's body fluids (blood, saliva, vomit, mucus, etc.) your signature on this form gives permission for us to get your child's blood drawn for infectious disease status, as defined by Virginia law and authorizes the testing facility to release the test results to the injured employee.

Your signature on this form affirms that you understand these policies, have had the opportunity to have questions answered to your satisfaction and will comply with all items. **You also agree to be responsible for all account balances.**

Parent/Legal Guardian Signature: _____ **Date:** _____

Medical History

PATIENT NAME _____ Birth Date _____

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

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No | | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



The Smile Questionnaire

Patient's Name: _____

In order to accurately evaluate your needs and expectations please help us by answering the following questions.

What is your primary concern? _____

Do you feel your teeth are (circle all responses):

Too small or short? No Yes

Too large or long? No Yes

Crooked or crowded? No Yes

Misshaped (uneven/pointed)? No Yes

Off Color? No Yes

Do you feel the front teeth are **too far forward** ("Buck Teeth)? No Yes

Are there **spaces** between the teeth that you do not like? No Yes

Do you see **too much or too little gum tissue** when smiling? No Yes

Have you (or your child) experienced **previous orthodontic treatment** (including braces or other appliances)? No Yes

If so, when? _____

How often do you brush? _____

Floss? No Yes

Last dental visit? _____ For what? _____

Are there other **dental issues not listed** above that you would like to have changed?

No Yes (explain) _____

Girls Only: Have you started your monthly periods? No Yes

If yes, approximately when? _____

Signature: _____ **Date:** _____

Relationship to Patient: _____