CARING FOR KIDS & PARENTS

901 Enterprise Pkwy, Suite 500 | Hampton, Virginia 23666 | Phone: (757) 896-4900

PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____
(last) (first)

Birth Date: _____ SS#: _____ E-mail address: _____

Marital Status (Please check one): Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Sex: M ☐ F ☐

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you? _____

PARENT/GUARDIAN OR SPOUSE INFORMATION

Name: _____ Relationship to patient: _____
(last) (first)

Birth Date: _____ SS#: _____ E-mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PRIMARY INSURANCE

Name: _____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SS#: _____

Employer: _____

Insurance Company: _____

Name: _____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SS#: _____

Employer: _____

Insurance Company: _____

SECONDARY INSURANCE

Caring for Kids and Parents

MEDICAL HISTORY UPDATE

Patient Name _____ Birth Date _____

Email _____ Phone # _____

Physician's Name _____ Phone #_____

Emergency Contact _____ Phone # _____

Please answer all questions completely. If there is no applicable answer, please put NA.

Please list all current medications _____

Check if the above named patient has ever had OR has any of the following:

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism/ASD
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Born Premature
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Defect
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Coughing Blood
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Handicaps/Disability
- ☐ Headaches
- ☐ Hearing Impaired
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nursing
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Skin Rash
- ☐ Speech Problems
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

PLEASE CIRCLE YES OR NO WHERE APPLICABLE:

Allergic to latex? **YES NO**

Allergic to nickel/metals? **YES NO**

Allergic to plastic? **YES NO**

Other Allergies? **YES NO**

If yes, please list allergies and reactions: _____

Require antibiotics before orthodontic treatment? **YES NO**

Any previous surgeries or hospitalizations? _____

Please explain any medical issues, problems, or conditions _____

DENTAL HISTORY

General Dentist's name? _____MM/YY of last routine dental visit?_____

Any difficulty with previous medical or dental visits? **YES NO**

if yes, please explain: _____

Have there been any injuries to the face, mouth, teeth, or chin? **YES NO**

Please explain any current dental issues, problems, or difficulties _____

Suck thumb/finger	**YES NO**	Chew hard objects	**YES NO**	Mouth Breathing **YES NO**
Suck/Bite Lips	**YES NO**	Grind Teeth	**YES NO**	
Bite/Chew nails	**YES NO**	Clench Jaw	**YES NO**	

Are there any specific dental questions or concerns? _____

AUTHORIZATION AND RELEASE

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

Patient/Parent/Guardian's Signature _____ Date _____

ABOUT DENTAL INSURANCE

Even if you have dental insurance, payment is your responsibility, but we can help. Regardless of what we might calculate as your dental benefits in dollars, we must stress the fact that as the patient, you are responsible for the total treatment fee. Dental insurance does not pay all fees, but is a great supplement to allow you to obtain the highest quality of dental care available.

As a courtesy to you, we do accept assignment of benefit payments for most insurance companies. This will reduce your immediate out-of-pocket expenditures. Our estimates are based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make payment. After that period of time, all inquiries, follow ups, and payments due, become the responsibility of you, the patient.

I understand that after the 60-day period of time, I am responsible for ALL fees, regardless of insurance coverage. Interest charges of 1.5% per month (18% per year) will be added to the entire unpaid balance after 60 days. I agree to pay all costs of collection, including, but not limited to, reasonable attorney's fees.

Signature Date

ACCIDENTAL EXPOSURE FROM PATIENT TO STAFF

The law in Virginia provides, that whenever any person who is rendering health care services to a patient, and is directly exposed to the patients' bodily fluids through an accidental needle stick, the patient will consent to be tested for HIV, Hep B and Hep C. Caring for Kids and Parents would be responsible for all lab fees. The results will be released to the person who was exposed to the bodily fluids.

Signature Date

HIPAA Consent Form

Caring for Kids and Parents

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, We Shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act Of 1996 (HIPAA).

The patient understands that

- Protected health information (PHI) may be disclosed or used for treatment payment or health care operations
- The practice has a Notice of Privacy Practices and that the patient can review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this consent

☐ Caring for Kids and Parents has permission to use any contact information written on patient registration form.

By checking this box, you give permission for the practice to leave, as thorough of a message as needed, from our dental office. This will include, but not limited to, appointment day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS is not considered 100% secure. (Examples include cell phones, email and fax lines)

If you did not check the box above, below is a list of ways the office may contact you. Please check any that you DO NOT want the office to contact.

☐ Work Phone ☐ Work Email ☐ Work Fax ☐ Mail to Work ☐ Personal Cell
☐ Home Phone ☐ Home Email ☐ Home Fax ☐ Mail to Home ☐ Emergency Contact
☐ Any of the above

FOR PATIENTS UNDER 18 YEARS OLD

I give consent to the following people to accompany my child/children to their dental appointments and to act on my behalf to give consent for dental or diagnostic treatment. I also give them permission to receive private information about my child/children's financial information, health history, condition, recommended treatment, past dental treatment received, etc.

Name	Relationship to Child	Phone Number

FOR PATIENTS 18 AND OLDER

I give consent to the following people to have access to my private information in my chart including financial information, health history, past treatment received, future treatment recommended, etc.

Name	Relationship to Patient	Phone Number

Patient gives office permission to forward any verified contact information and PHI to patients ' specialists. Office may discuss pertinent patient information, including PHI, with labs, and product representatives Involved in patient's case through verified, unsecured. unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not entities, treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients' case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient Name _____

Print Parent/Legal Guardian Name _____

Signature of Patient or Parent/Guardian _____ Date _____

☐ Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

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Appointment Confirmations/Broken Appointments

We understand that everyone's time is important. However, once you make an appointment for either yourself or someone in your family, we expect you to keep it unless it is canceled at least 48 hours before the time slot that has been reserved for you or your family member. We will give you several opportunities to cancel and re-schedule well in advance should you need to do so. Our office policy is to send you a reminder one (1) week before the scheduled time, and a second reminder three (3) days before. If neither of those is confirmed via email or text, you will receive a phone call to confirm your appointment. We reserve the right to charge you $100 for an appointment that is broken, that is not canceled, or rescheduled at least 48 hours before your confirmed scheduled appointment. We have a busy practice, and if you fail to show for your appointment, it takes a time slot away from other patients within our practice. Our office also understands that circumstances do arise that may prevent you from coming even though you may have confirmed. But please do your best to give us at least a 48-hour notice so we may use that time to serve other patients.

_____ _____

Patient/Legal Guardian/Parent Signature Date