

CARING *for* KIDS & PARENTS
MEDICAL HISTORY

Patient Name _____
 Email _____
 Physician's Name _____

Birth Date _____
 Phone # _____
 Phone # _____

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

Are you allergic to latex? Y N

Are you taking any medications now? Y N If yes, please list _____

Are you pregnant? Y N Have you ever had a sleep test? Y N CPAP machine ever been recommended? Y N

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

	Y	N		Y	N		Y	N		Y	N
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	or Sleeping Pills	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Wine or Foods	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other Narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>

Additional information about your health that we should know: _____

Have you ever been hospitalized? Y N If so, when: _____

Were you ever advised by your doctor to have antibiotics before any medical or dental treatment? Y N

Have you ever had any serious trouble associated with any previous dental treatment? Y N

If so, please explain: _____

DENTAL HISTORY

	Y	N		Y	N
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	If so, how often? _____		
Sore areas in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Pain in or near your ears	<input type="checkbox"/>	<input type="checkbox"/>	If so, how often? _____		
Sensitivity to heat, cold or sweets	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches or tired jaw	<input type="checkbox"/>	<input type="checkbox"/>	if so, how often? _____		
Have you ever been treated by a Periodontist? (gum specialist)	<input type="checkbox"/>	<input type="checkbox"/>	Do you use smokeless tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated by and Orthodontist? (braces)	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a specific Dental problem or pain?	<input type="checkbox"/>	<input type="checkbox"/>	if no, why not _____		
If yes, please explain: _____					
Were Panoramic x-rays (full mouth x-rays) taken within the last 3 years that you can obtain from your previous dentist?				<input type="checkbox"/>	<input type="checkbox"/>

Patient or Guardian's Signature _____ Date _____

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: _____

SECONDARY INSURANCE

Name: _____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SS#: _____

Employer: _____

Insurance Company: _____

ABOUT DENTAL INSURANCE

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 you, the patient, are responsible for the total treatment fee. Dental insurance is not a pay-all, but is a great supplement to allow you to obtain the highest quality of dentistry 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 this time, all inquires, follow-ups, and payments due, become your responsibility.

I understand that 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 cost of collection, including, but not limited to, reasonable attorney's fees.

Signature

Date



The law in Virginia provides that whenever any person who is rendering health care services to a patient is directly exposed to the patient's bodily fluids in a manner that may, according to the current guidelines of the Center for Disease Control, transmit human immunodeficiency virus (AIDS virus) or Hepatitis B or C viruses, the patient will be deemed to have consented to testing for infection with the AIDS virus and Hepatitis B or C viruses without actual consent but with knowledge. The results of this test will be released to the person who is exposed to body fluids, also without actual consent.

Signature of Patient or Guardian

Date

Michael P. McCormick, Jr., DDS
General Dentistry

Tetyana McCain, DDS
Pediatric Dentistry

Walt Wexel, DDS
Orthodontist

901 Enterprise Parkway, Suite 500 Hampton, Virginia 23666 | 757-896-4900 | Fax 757-896-4905

HIPAA Consent Form

From the office of: Caring for Kids & 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 & 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

Please list the names of any people who can have access to your chart. Please state what part of your chart you want people with partial access to be able to receive (financial, treatment, health history, etc.).

_____ Full Access/ Partial Access _____

_____ Full Access/ Partial Access _____

_____ Full Access/ Partial Access _____

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 _____ Date _____

Print Parent/Legal Guardian Name _____ Date _____

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.