**Caring for Kids & Parents**

# MEDICAL HISTORY

Patient Name ______________________________ Birth Date ______________________
Email ______________________________ Phone # ______________________
Physician's Name ______________________________ Phone #______________________

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

Please list all current medications ______________________________
Is your child allergic to latex? YES NO

Does your child have, or have they ever had any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Asthma | YES | NO | Rheumatic Fever | YES | NO | Heart Murmur | YES | NO |
| Cancer | YES | NO | Congenital Heart Defect | YES | NO | ADD | YES | NO |
| Hepatitis | YES | NO | Handicaps/Disabilities | YES | NO | ADHD | YES | NO |
| HIV/AIDS | YES | NO | Seizures/Epilepsy | YES | NO | Autism/ASD | YES | NO |
| Hemophilia | YES | NO | Tuberculosis | YES | NO | | | |
| Diabetes | YES | NO | Abnormal Bleeding | YES | NO | | | |
| Allergies | YES | NO | | | | | | |

if yes, please list allergies and reactions:
______________________________

Does your child require antibiotics before dental treatment? YES NO
Has your child had any difficulty with previous medical or dental visits? YES NO
if yes, please explain: ______________________________
Has your child had any previous surgeries or hospitalizations? ______________________________
Please explain any medical issues, problems or conditions your child has ______________________________
Please explain any current dental issues, problems or difficulties ______________________________

## DENTAL HISTORY

How often does your child have their teeth brushed? ____________________
How often does your child have their teeth flossed? ____________________
Is your child's water fluoridated(unfiltered)? YES NO
Does your child take fluoride supplements? YES NO

Does your child:

| | | |
|---|---|---|
| Suck thumb/finger | YES | NO |
| Suck/Bite Lips | YES | NO |
| Bite/Chew nails | YES | NO |
| Chew hard objects | YES | NO |
| Grind Teeth | 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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Parent or Guardian's Signature ______________________________ Date ________________

# CARING FOR KIDS & PARENTS

901 Enterprise Pkwy, Suite 500 | Hampton, Virginia 23666 | 757-896-4900

## PATIENT INFORMATION

Name: ____________________________________________ M___ F___ Date of Birth: ______________________

Name: ____________________________________________ M___ F___ Date of Birth: ______________________

Name: ____________________________________________ M___ F___ Date of Birth: ______________________

Name: ____________________________________________ M___ F___ Date of Birth: ______________________

Name: ____________________________________________ M___ F___ Date of Birth: ______________________

Who referred you to us? _________________________________________________________________________

## PARENT/GUARDIAN INFORMATION

Name: __________________________________________ Relationship to patient: ____________________________
(last) (first)

Birth Date: __________________ SS#: __________________ E-mail address: ______________________________

Address: ______________________________________ City: ____________________ State: _______ Zip: ___________

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: _____________________

## SPOUSE/OTHER PARENT 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 <u>DO NOT</u> 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 <u>45 CFR 164.506</u>. 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.

# AUTHORIZATION TO GIVE CONSENT FOR DENTAL TREATMENT

I give consent to the following family members, and friends, to accompany my child/children to their dental appointments, and to act on my behalf to give consent for any dental, or diagnostic treatment. I also give permission for the following people to receive private information about my child/children's health history, and to allow this person to know about my child/children's condition, treatment, or past dental treatment received.

| First Name Last Name | Relationship to Child | Phone Number |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

Print Patient Name ______________________________ Date ______________

Print Parent/Legal Guardian Name ______________________________ Date ______________

Signature of Patient or Parent/Guardian ______________________________ Date ______________