

*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? _____	Does your child:	Suck thumb/finger	YES	NO
How often does your child have their teeth flossed? _____	Suck/Bite Lips	YES	NO	
Is your child's water fluoridated(unfiltered)? YES NO	Bite/Chew nails	YES	NO	
Does your child take fluoride supplements? 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

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## 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? \_\_\_\_\_

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## 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: \_\_\_\_\_

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## 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.

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Signature

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Date

# 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.

- |   |                                     |                                   |                                       |  |
|---|-------------------------------------|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Work Phone       | <input type="checkbox"/> Work Email | <input type="checkbox"/> Work Fax | <input type="checkbox"/> Mail to Work | <input type="checkbox"/> Personal Cell     |
| <input type="checkbox"/> Home Phone       | <input type="checkbox"/> Home Email | <input type="checkbox"/> Home Fax | <input type="checkbox"/> Mail to Home | <input type="checkbox"/> Emergency Contact |
| <input type="checkbox"/> 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.

## 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
First Name	Last Name	Relationship to Child	Phone Number
First Name	Last Name	Relationship to Child	Phone Number
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 \_\_\_\_\_