Patient Information

CHILD'S NAME	BIRTHDATE	AGE	GENDER (SEX)
SOCIAL SECURITY NO.	HOME PHONE NO.		
ADDRESS			

Nickname: _____

Hobbies: _____ Favorite color: _____

Whom may we thank for referring you? _____

Parent/Guardian Information

NAME
ADDRESS (IF DIFFERENT FROM PATIENT)
HOME PHONE NO. (IF DIFFERENT FROM PATIENT)
CELL PHONE NO. (IF DIFFERENT FROM PATIENT)
EMPLOYER
SOCIAL SECURITY NO.
BIRTHDATE / RELATIONSHIP
EMAIL

NAME
ADDRESS (IF DIFFERENT FROM PATIENT)
HOME PHONE NO. (IF DIFFERENT FROM PATIENT)
CELL PHONE NO. (IF DIFFERENT FROM PATIENT)
EMPLOYER
SOCIAL SECURITY NO.
BIRTHDATE / RELATIONSHIP
EMAIL

Insurance Information

Do you have dental insurance coverage for a minor/child?

○ Yes ○ No

INSURANCE CO.
PHONE NO.
CLAIMS ADDRESS
GROUP NO.
POLICY/ID NO.

Do you have secondary insurance coverage for a minor/child?

○ Yes ○ No

INSURANCE CO.
PHONE NO.
CLAIMS ADDRESS
GROUP NO.
POLICY/ID NO.

Patient Information

CHILD'S NAME

Dental History

CHILD'S PHYSICIAN	CITY/STATE	PHONE NO.
DATE OF LAST PHYSICAL EXAM	CURRENT MEDICAL CONDITIONS	

LIST OF ALLERGIES (LATEX, ETC.)

Has your child complained about dental problems? Y N
Does child brush teeth daily? Y N
Any unhappy dental experiences? Y N
Is fluoride taken in any form? Y N
Any injuries to mouth, teeth, head? Y N
Does child floss every day? Y N

NAME/PHONE NUMBER OF PREVIOUS DENTIST:
DATE OF LAST VISIT TO A DENTIST:
DATE OF LAST CLEANING/FLUORIDE:
DATE OF LAST X-RAYS:

Any mouth habits? ○ thumb sucking ○ nail biting ○ mouth breathing ○ pacifier ○ sleeping with bottle
Other (please explain)

Does your child have Congenital Heart Disease? Y N Is *SBE prophylaxis* required? _____
Is child receiving any medication or drugs? Y N List of Medications _____
Has child ever been hospitalized? Y N If so, why? _____
Has child ever had surgery? Y N List surgeries _____
Is there excessive bleeding when cut? Y N Handicaps/Disabilities? _____

Has your child ever had any history of or difficulty with any of the following? If yes, please circle.

ADD/ADHD	Congenital Heart Defect	Kidney/Liver Disease	Other (please explain)
AIDS/HIV	Convulsions/Seizures	Learning Disability	_____
Anemia (Sickle Cell or Low Iron)	Diabetes	Measles	_____
Asthma	Drug/Alcohol Abuse	Mononucleosis	_____
Artificial Heart Valves	Epilepsy	Mumps	_____
Autism	Psychological Problems	Rheumatic Fever	
Bladder Problems	Hearing Impairment	Sinus Problems	Additional Notes:
Fainting	Heart Murmur	Thyroid Disease	_____
Cerebral Palsy	Hepatitis	Tuberculosis	_____
Chicken Pox	Hemophilia	Cancer/Tumors	_____

Emergency Contact

In the event of an emergency, whom should we contact/ whom is authorized to attend appointment with child other than parent?

NAME	RELATIONSHIP	PHONE NO.
NAME	RELATIONSHIP	PHONE NO.

PEDIATRIC DENTISTRY

20405 Exchange Street • Suite 260 • Ashburn VA 20147 • Tel 703.729.0350 • Fax 703.729.0461 • info@ashburnpedo.com

Signatures

CHILD'S NAME

Financial Policy

CONSENT AND AUTHORIZATION: I authorize dental treatment on my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Pediatric Dentistry of One Loudoun. Without any reservations, I agree to abide by the policies outlined herein.

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Privacy Policy

I, _____ received a copy of this office's Notice of Privacy Practices.*

CONSENT FOR TREATMENT: The information that I have given is correct and completed to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the LEGAL GUARDIAN of the patient. I authorize Dr. Rivas/authorized associates/staff to perform the necessary dental procedures including, but not limited to the use of Nitrous Oxide (laughing gas), Lidocaine (Novacaine-like), and any necessary xrays on my child.

PROCEDURES WILL ALWAYS BE DISCLOSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Notice of Privacy Practices

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment of health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have to the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following: a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; i.e. release of radiographs and or treatment plans to referring physicians and or dentists) b) Obtaining payment from third party payers (i.e. my insurance company) c) The day-to-day healthcare operations of your practice.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Compliance Assurance Notification for Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for out patients.

It is our policy to properly determine appropriate uses of PHI in accordance with government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosures of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of that fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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Financial Policy

Thank you for choosing us to provide your child's dental care! We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE:
Our office is dedicated to providing all of our patients with the finest treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay. Please review the following in regards to your dental insurance coverage:

- We must emphasize that as a dental care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you and your insurance company.
- As a courtesy, we will file your insurance claims. Any amount determined not to be covered by your insurance is due at the time services are rendered. These fees may include deductibles, co-payments, and procedures not covered by your insurance policies.
- If insurance does not pay my claim within 60 days, payment is expected from the responsible party within two weeks.

PAYMENT POLICY:

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, Discover and CareCredit.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance.
- We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

PATIENTS WITHOUT INSURANCE COVERAGE:
We provide written estimate of fees and payment is expected at each visit for services rendered. We are happy to provide discounts for services paid in full up front. Payment arrangements may also be offered prior to treatment.

MINOR PATIENTS:
The parent or guardian accompanying the minor is responsible for full payment. We will look to the adult accompanying a minor for all services rendered to minor patients.

Our doctor and staff will discuss with you the cost of treatment and each of the available payment plan options so that you are able to make the best choice for you and your child. We take our reputation for being a generous office very seriously and we will work with you to make this process as easy as possible. We are so excited to be treating your child!

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