VILLAGE pediatric dentistry

Date: _____

## PATIENT INFORMATION

Patient's Name: _____
Last First MI Nickname

DOB: _____ Age: _____ Sex: _____ Ethnicity: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Names & ages of other children in family: _____

School: _____ Grade: _____ Hobbies: _____

Parent/Legal Guardian: _____ Relation to patient: _____

Employer: _____ Phone: _____

Parent/Legal Guardian: _____ Relation to patient: _____

Employer: _____ Phone: _____

Who has legal custody of patient? _____ Dental Insurance: _____

Person responsible for payment account: _____ SS No: _____ DOB: _____

Name of child's physician/group: _____ Phone: _____

Whom may we thank for referring you to our office? _____

What is the reason for your child's dental visit? _____

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## MEDICAL HISTORY

Child's Name: _____ Preferred Name: _____
Date of Birth: _____ Age: _____ Gender: _____ Grade: _____ School: _____
Pediatrician: _____ Office Phone: _____
Hobbies/Interests/Pets: _____ Siblings Names/Ages: _____

YES ☐ NO ☐ Is your child under the care of a physician for anything other than routine care?
If yes, please explain: _____

YES ☐ NO ☐ Does your child have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?
If yes, please circle which one. Who is the treating/diagnosing physician? _____

YES ☐ NO ☐ Does your child have any drug allergies or ever had a reaction to a DRUG or MEDICATION?
If yes, please list the drugs and the reaction: _____

YES ☐ NO ☐ Does/Did your child have allergies or a reaction to LATEX, FOODS, DYES, METALS, or ANYTHING ELSE?
If yes, please circle which & indicate if it's airborne, or ingested, & explain: _____

YES ☐ NO ☐ Does your child take any medications on a regular basis?
If yes, please list: _____

YES ☐ NO ☐ Is your child currently taking any medications that he/she does not normally take on a regular basis? If yes, please list and explain: _____

YES ☐ NO ☐ Has your child EVER been a patient in a hospital or emergency room for ANY reason?
If yes, please list and explain: _____

YES ☐ NO ☐ Does your child or anyone in your family have a condition called methylenetetrahydroflate reductase deficiency (MTHFR) or hyperhomocysteinemia?

Please check any condition your child currently has or has ever had. If NONE apply, please check NONE.

| | | | |
|---|---|---|---|
| ☐ Asthma<br>Controlled?<br>Last attack?<br>What started attack?<br>Inhaler with you?<br>☐ Allergy<br>☐ Breathing/Lung Problem<br>☐ Diabetes<br>☐ Endocrine Problem<br>☐ Adrenal/Kidney Problem<br>☐ Intestinal/Stomach Problem<br>☐ Liver Problem<br>☐ Heart Disease/Murmur<br>☐ High/Low Blood Pressure<br>☐ Rheumatic Fever<br>☐ Arthritis | ☐ Bone Disorder<br>☐ Skin Disorder<br>☐ Premature Birth<br>☐ Low Birth Weight<br>☐ Failure to Thrive<br>☐ Developmental/Mental Delay<br>☐ Physical Challenge<br>☐ Cerebral Palsy<br>☐ Brain Disorder<br>☐ Eye/Ear Disorder<br>☐ Nose/Throat Disorder<br>☐ Cleft Lip/Palate<br>☐ Speech Problem<br>☐ Feeding/Eating Problems<br>☐ Neuromuscular Problems<br>☐ Congenital Birth Defect | ☐ Seizure/Epilepsy<br>Last seizure?<br>What started seizure?<br>☐ Cancer/Tumors<br>☐ Leukemia<br>☐ Hepatitis (A, B, C)<br>☐ HIV/AIDS<br>☐ Tuberculosis<br>☐ Anemia<br>☐ Sickle Cell Trait/Disease<br>☐ Blood Transfusion<br>☐ Blood Disease<br>☐ Excessive Bleeding<br>☐ Tonsils/Adenoids Removed<br>☐ Tubes in Ears<br>☐ Sleep Apnea/Snoring | ☐ Reflux<br>☐ Fainting<br>☐ POTS<br>☐ Headaches<br>☐ Facial/Jaw Joint Pain<br>☐ Artificial Joint/Screw/Rod<br>☐ Pregnancy<br>☐ Head/Mouth/Teeth Injury<br>☐ Radiation/Chemotherapy<br>☐ ADD/ADHD<br>☐ Hyperactivity<br>☐ Anxiety/Nervousness<br>☐ Autism/Asperger's<br>☐ Behavior/Psychiatric Issues<br>☐ Learning Concerns<br>☐ NONE |

If any of the above were checked, please explain: _____

YES ☐ NO ☐ Is there anything else you would like us to know or that we need to know about your child's health? If yes, please explain: _____

The above medical/dental and medication history is complete and accurate to the best of my knowledge.
I will notify you of ANY change in the above prior to ANY appointment.

_____ _____
Signed (Parent/Guardian) Date

VILLAGE pediatric dentistry

## DENTAL HISTORY

Child's Name: _____ Date of Birth: _____

What is the reason for your visit today: 1st Visit, Checkup, Discomfort, Habit, Orthodontics, Emergency
Other: _____

YES ☐ NO ☐ Has your child ever seen a dentist before?
If yes, by whom and approximately when?: _____
YES ☐ NO ☐ Were x-rays taken?
If yes, approximately when were the last x-rays taken? _____
YES ☐ NO ☐ Has your child had a traumatic medical or dental experience?
If yes, please explain: _____
YES ☐ NO ☐ Has your child ever injured any teeth or his/her mouth?
If yes, please explain: _____
YES ☐ NO ☐ Has your child ever experienced facial pain or had problems with the jaw joints near each ear?
YES ☐ NO ☐ Do you expect your child to be uncooperative?
YES ☐ NO ☐ Are you on well water?
YES ☐ NO ☐ Does your child drink NON-fluorinated water?
YES ☐ NO ☐ Does your child take fluoride tablets, drops, or vitamins with fluoride?
YES ☐ NO ☐ Is your child a toothpaste eater?
YES ☐ NO ☐ Does your child suck his/her thumb, finger, pacifier, blanket, etc.?
YES ☐ NO ☐ Does your child grind his/her teeth?
YES ☐ NO ☐ Does your child go to sleep with a bottle?
If yes, what's in the bottle? : _____
YES ☐ NO ☐ Does your child have difficulty breathing through the nose with his/her mouth closed?
YES ☐ NO ☐ Is there anything else you would like us to know or that we need to know about your child's health?
If yes, please explain: _____

The above medical/dental and medication history is complete and accurate to the best of my knowledge.
I will notify you of ANY change in the above prior to ANY appointment.

_____ _____

Signed (Parent/Guardian) Date

VILLAGE
pediatric dentistry

## CONSENT FOR CARE

Parents: Prevailing medical/dental practice law requires that we ask you to read the following and sign at the bottom. We apologize, in advance, for the impersonal nature of this form.

I am the parent or legal guardian of _____ and I have legal authority to give consent for medical/dental treatment for him/her. I do hereby request and authorize the dental staff of Village Pediatric Dentistry to perform dental services for my child, including, but not limited to comprehensive examinations, cleanings, x-rays and photographs as necessary for diagnostic purposes, any necessary treatment, and the administration of anesthetics that are deemed advisable by Dr. Monica Sharma, even in the event I am not present when treatment is rendered. I understand that dental treatment for children includes efforts to guide behavior by helping them understand the treatment in terms appropriate for their age.

**Note about the first Appointment**

During most first appointments, we:

- Perform an examination of the teeth, gums, and surrounding tissues
- Apply a highly concentrated fluoride to the teeth
- Take x-rays (x-rays are indicated during many, but not all, first appointments)
- Review proper oral hygiene methods in a manner appropriate to your child's age

If you are concerned about or object to any of these procedures, please let us know BEFORE we begin.

_____ _____

Signature (Parent/Guardian) Date

_____ _____

Patient's Name Patient #

VILLAGE pediatric dentistry

5830 Bond Street. Ste. 350
Cumming, GA 30040
678.456.5572

# HIPAA Privacy Statement
## *Patient Consent Form*

I understand that I have certain rights to privacy regarding my protected health information. These rights are given me under the Health Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health care information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

PATIENT NAME (print) _____

Relationship to Patient _____

Signature _____ Date _____

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## FINANCIAL POLICY

We accept the following forms of payment: Visa, MasterCard, Cash, or Check ($50 fee for any returned checks). Payment is due in full at the time when services are rendered. The parent/legal guardian is responsible for payment of all patient accounts. All statements will be sent to this individual. We will not bill a third party. We will be happy to file your insurance claim and accept benefit of payments from your insurance company.

**Our relationship is with you**! It is important to understand that we don't work for an insurance company; we work completely for our patients. Dental insurance can be a wonderful benefit for many families, and we want you to know we will work to insure you get the benefits allotted in your insurance contract. Please realize, however, that we have no relationship with any insurance company. We are not signed up with any insurance plans. We are not on any insurance lists. We have no control over your plan, which procedures the insurance company will cover, or how much they cover for specific procedure. We have a relationship only with you the patient. Your insurance company has a relationship with you and a responsibility to you, but not to us. **The treatment recommended for your child will be based on what is best for your child's dental health—not on what your insurance may or may not cover.**

Most insurance companies will pay only a portion of the fee for service. You will be responsible for the full balance that the insurance company does not pay. As a courtesy, we will accept your complete insurance form, file the insurance for you, and accept payment from your insurance company under the following conditions only:

- We require payment in full, from the legal guardian, for the estimated portion which the insurance company will not cover at the time services are rendered. Please be prepared to pay any deductible, co-pay, or other expense at time of service.
- When we receive payment from the insurance company, we will compare what they paid to what we estimated and adjust your balance accordingly. You may still have a small balance, or you may get a small credit.
- Insurers vary widely in what services they will pay for and how much they will pay. Determining how much your insurer will reimburse for a procedure is best accomplished by you calling your insurer and asking them.
- We can accept payment from an insurance carrier only when they directly assign benefit payments to our office. Some plans will send payments directly to you. In these cases, we require payment in full for all services rendered at time of service.
- You are responsible for keeping us updated with any changes in your insurance policy.
- We will file a predetermination for recommended treatment when it is requested by you.
- If your insurance company requires a referral, you are responsible for obtaining it.
- It is the parent's responsibility to ensure the insurance makes prompt payment. If your insurance company does not make payment to us within 45 days after service is provided, balance is due and payable in full immediately by the parent/legal guardian.
- If a balance remains after insurance payment is received, we will send one statement at no charge. If more than one statement is sent, a charge of 1.5% per month (18%APR) will be added to each notice. Minimum charge of $8. If we communicate with you using certified mail the current fee for each account is $12.
- If your account balance becomes 120 days past due, we will take necessary steps to collect this debt. In the event of default payment, guardians shall pay any legal interest on the balance due, together with any collection cost. Reasonable attorney fees to incurred to effect collection of the account or future outstanding accounts will be the responsibility of the legal guardian.

About "UCR": insurance companies sometimes state that reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR"). This can be misleading, especially as insurance companies imply your dentist is "overcharging" rather than say they are "underpaying". Insurance companies set their own fees and each uses a different set of fees they consider allowable. These fees may vary widely as each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR fee. Frequently this data can be old and these "allowable" fees are set by the insurance company such that the insurer can be quite profitable. Often a less expensive policy will use a lower, usual, customary, or reasonable (UCR) figure.

If you cancel or miss your appointment without giving 48 hours' notice, there will be a $75 fee added to your next appointment.

If your account balance becomes 120 days past due, we will take necessary steps to collect this debt. In the event of default payment, guardians shall pay any legal interest on the balance due, together with any collection cost. Collection fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of the account or future outstanding accounts will be the responsibility of the legal guardian.

I have read, understand, and agree to the financial policies of Village Pediatric Dentistry.

Parent/Legal Guardian Name (Printed) Parent/Legal Guardian Signature Date