piedmont pediatric dentistry

NEW PATIENT FORM

Practice Location:
□ Charlottesville □ Waynesboro

PATIENT

Name _____ DOB _____

Preferred Name _____ Gender □ M □ F

Address _____ Other children in family? List names/ages:

_____ _____

_____ _____

With whom does the patient live? _____ _____

Who may we thank for referring you to our practice? _____

FATHER / LEGAL GUARDIAN 1

Name _____
□ *Address same as patient*

Address _____

_____

_____

Phones Home _____

Mobile _____

Work _____

E-mail _____

Employer _____

SSN _____ DOB _____

□ Not biological father. Specify relation _____

MOTHER / LEGAL GUARDIAN 2

Name _____
□ *Address same as patient*

Address _____

_____

_____

Phones Home _____

Mobile _____

Work _____

E-mail _____

Employer _____

SSN _____ DOB _____

□ Not biological mother. Specify relation _____

DENTAL INSURANCE

1) Carrier: _____ Policy No.: _____

Subscriber: _____ Group No: _____

Employer: _____

2) Carrier: _____ Policy No.: _____

Subscriber: _____ Group No: _____

Employer: _____

CONSENT BY PROXY FOR DIAGNOSTIC AND PREVENTIVE CARE: I appoint the following individuals as proxy decision makers for consenting to routine diagnostic/preventative dental services and are the only individuals authorized to accompany the patient to appointments other than the parent/legal guardians. I understand that a parent/legal guardian must consent and be present to consent to all other services (surgical, medical, emergency, etc.). I also understand that if an unauthorized person accompanies the patient, the appointment will be rescheduled and treated as a "no show". I have the legal right to delegate consent to the proxy decision maker, who is an adult (18+) and is legally/medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

CONSENT FOR DENTAL TREATMENT

Version 06012015

I request and authorize a licensed dentist employed by Piedmont Pediatric Dentistry PLC, the "Practice", to perform diagnostic and preventative dental services as well as related surgical and/or medical treatments as deemed necessary. I also request and authorize members of the clinical staff qualified to perform diagnostic and preventative dental services to do so as deemed necessary. The risks and benefits of these services and treatments will be explained as needed. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand treatment in methods appropriate for their age. I also understand and consent to digital photographs of the face to be taking as part of the clinical record. The dentist and the staff will provide an environment likely to help children learn to cooperate during treatment by using various behavior guidance techniques, including praise and explanation/demonstration of procedures and instruments.

CONSENT FOR PAYMENT AND SERVICES

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Therefore, payment is due on the date that services are rendered. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients/legal guardians understand that all dental services furnished are charged directly to the Guarantor and that any balance remaining, after the insurance payment is received, is due upon receipt of either the insurance company's "Explanation of Benefits" or a billing statement from our office. The Guarantor is personally responsible for payment of any and all dental services regardless if the patient is covered under an insurance policy. Patients/legal guardians who carry dental insurance must bring a copy of the current insurance card to each appointment and please inform our office as soon as possible of any changes to the legal name, contact information and/or active duty status of the patient, legal guardian(s) and/or Guarantor. This will allow our office to have accurate and up-to-date insurance information, estimates, and to reduce errors in insurance filing.

As a courtesy, not an obligation, our office will help file insurance forms and/or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office does render services on the assumption that our charges will be paid by an insurance company. If insurance does not pay expected and/or estimated amount, the Guarantor will be held responsible for any outstanding balance on the patient's account. Any questions concerning insurance benefits should be directed to your insurance company's representative or benefits office. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any account exceeding 60 days past due will be sent to an attorney and/or collections agency. In this event, the Guarantor will be held responsible for any and all fees associated with the collection process.

A 5% discount is applicable to an account that settles with a full-cash payment for all services rendered on the date of service. Our office cannot accept credit card payments for less than $10.00. Our office cannot finance/offer payment plans for any balances due; however, CareCredit® financing is accepted for qualified accounts; all checks returned unpaid for Not Sufficient Funds will automatically be charged a $40.00 fee.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered by this office to me, my spouse or my child, or at my request, I agree to pay therefore the reasonable value of said services to the Practice, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees should any account due from me be referred to an attorney for collection.

I understand that this office has a strict 24-hour cancellation/no-show policy. Unforeseen circumstances do occur and sometimes require missing an appointment; however, if an appointment is missed without proper notice, we have policies in place to protect the appointment times for your child and other children that need care. Failure to provide proper notice for Recall appointments will result in a $40 fee and for Restorative/Surgical appointments a $75 fee. Failure to provide proper notice for Restorative/Surgical appointments in our Waynesboro location will be subject to immediate dismissal from the practice. A $100 fee will be assessed for failure to provide proper notice for any Oral/IV/IM Sedation and General Anesthesia appointments and will result in immediate dismissal from the practice. Arriving 15 or more minutes late to any scheduled appointment is considered a no-show. If more than two scheduled appointments are missed, dental services will no longer be able provided for your child and will result in dismissal from our practice.

As a courtesy our office provides telephone, e-mail and/or text message appointment reminders managed by third-party software which relies upon accurate patient contact information in our database. If, for any reason, our office does not issue a reminder or issues an incorrect reminder, the parent/legal guardian will assume responsibly for the patient's originally scheduled appointment time or an appointment rescheduled via telephone or internet.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. The purpose of this portion of the form is to obtain acknowledgement of receipt of our Notice of Privacy Practices and to document our good faith effort to obtain that acknowledgment. You will find the Notice posted in our reception area and it will also be available upon request at our front desk. You may refuse to have your signature apply to the Acknowledgement of Receipt of Notice of Privacy Practices section by checking this box □.

To the best of my knowledge the information on New Patient Form (reverse) is correct. I have read the above conditions of treatment and payment and agree to their content.

Signature of Legal Guardian	**Printed Name of Legal Guardian**	**Date**
Signature of Guarantor	**Printed Name of Witness**	**Date**

INTERNAL OFFICE USE: Attempted to obtain written Acknowledgment of Receipt of Notice of Privacy Practices, but not obtained because:
□ Individual refused to sign □ Communication barrier □ Emergency situation □ Other (please specify) _____

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HEALTH HISTORY

Practice Location:
□ Charlottesville □ Waynesboro

PATIENT

Name _____ DOB _____

Preferred Name _____ Age _____

MEDICAL CONDITIONS

Please indicate any current or past medical condition(s):

□ ADD/ADHD
□ Anemia
□ Aspergers
□ Asthma
□ Autism Spectrum Disorder
□ Birth Defect
□ Blood Disorders
□ Cancer
□ Cerebral Palsy
□ Cleft Lip and/or Palate
□ Cognitive Impairment
□ Developmentally Delayed
□ Diabetes □ Type 1 □ Type 2
□ Down Syndrome
□ Genetic Disorder
□ GERD
□ Eating Disorder
□ Eczema
□ Epilepsy / Seizures
□ Hearing Disorder
□ Heart Defect / Murmur
□ Heart Disease
□ Hepatitis
□ High Blood Pressure
□ History of Abuse
□ HIV/AIDS
□ Jaundice
□ Kidney Disease
□ Learning Disability
□ Liver Disease
□ Migrane Headaches
□ Pregnancy
□ Premature Birth
□ Psychiatric Disorder
  □ Anxiety/Panic
  □ Bipolar Disorder
  □ Depression
  □ Other
□ Obesity
□ ODD
□ Respiratory Problems
□ Rheumatic Fever / Rheumatism
□ Sickle Cell □ Disease □ Trait
□ Sinus Problems
□ Syndrome
□ Speech Disorder/Delay
□ Thyroid Disorder
□ Tuberculosis
□ Vision Disorder
□ Other / Not Listed *(specify below)*

If YES to any condition above, please explain: _____

_____

_____

_____

□ The patient has never been diagnosed with any condition, including those listed above.

HOSPITALIZATIONS AND SURGERIES / PROCEDURES

□ Adenoidectomy Date: _____
□ Ear Tubes Date(s): _____
□ Eye Surgery Date(s): _____
□ Heart Surgery (specify below) Date(s): _____
□ Tonsillectomy Date: _____
Dental Surgery under:
□ General Anesthesia Date(s): _____
□ Sedation (e.g. oral, IV) Date(s): _____

Other surgeries, procedures, and/or emergencies with date(s): _____

_____

_____

ALLERGIES

Drug Allergies: □ Y □ N Specify drug(s) and reaction: _____

_____

Environmental / Food Allergies: □ Y □ N Specify allergen(s) and reaction: _____

_____

MEDICATIONS

Please list all of the patient's current medication(s) and/or supplements: _____

_____

_____

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DENTAL HISTORY

INITIAL VISIT

What is your primary concern about the patient's oral health? _____

_____

If indicated today, the patient may receive the recommended: □ topical fluoride treatment □ x-rays

GENERAL

Is this the patient's first dental visit? □ Y □ N Date of last dental visit _____

Previous dentist _____ Date of most recent dental x-rays (s) _____

Reason for last dental visit _____

Has the patient ever had any injuries to the teeth, mouth, or face? □ Y □ N

If YES, explain _____

Does/did the patient have any oral habit(s) after one year of age? □ Y □ N If YES, until what age? _____

□ Finger/Thumbsucking □ Pacifier

□ Bottle, Sippycup □ Other

ORAL HYGIENE

Who brushes the patient's teeth? _____ How often are the patient's teeth brushed? _____ times per _____

Does someone regularly assist? □ Y □ N If YES, who _____

Who flosses the patient's teeth? _____ How often are the patient's teeth flossed? □ Daily □ Occasionally □ Never

Does someone regularly assist? □ Y □ N If YES, who _____

Does the patient's toothpaste contain fluoride? □ Y □ N

DIET

Is the patient's drinking water fluoridated? □ Y □ N Water Source □ City/Municipal □ Well □ Bottled

Is the patient receiving supplemental fluoride in any form? □ Y □ N Treatment Type(s) _____

Does your child eat or drink after bedtime brushing? □ Y □ N If YES, list _____

Does your child have a diet high in sugars or starches? □ Y □ N If YES, describe _____

Do you have any concerns about your child's weight? □ Y □ N If YES, describe _____

How frequently does your child have the following?

Candy or other sweets	□ Rarely	□ 1-2 times/day	□ 3+ times/day	Product _____
Chewing Gum	□ Rarely	□ 1-2 times/day	□ 3+ times/day	Type _____
Snacks between meals	□ Rarely	□ 1-2 times/day	□ 3+ times/day	Usual snack _____
Sweet Drinks *	□ Rarely	□ 1-2 times/day	□ 3+ times/day	Product _____

* Note: e.g. juices, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, energy drinks

DENTAL EXPERIENCE

How do you expect your child to react to dental treatment? _____

Has the patient ever had a problem receiving dental care? □ Y □ N

If YES, explain _____

Has the patient had previous orthodontic treatment (braces, spacers, other appliances)? □ Y □ N

If YES, explain _____

To the best of my knowledge the information provided on Health and Dental History forms is correct. I give my consent to the dentist(s) and staff of Piedmont Pediatric Dentistry to perform and provide the related treatment, services, behavior guidance techniques, local anesthesia and/or analgesia deemed necessary to prevent and treat any dental/oral deficiency, abnormality, and/or infection.

Signature of Legal Guardian **Printed Name of Legal Guardian** **Date**