

# **NEW PATIENT FORM**

Practice Location:

□ Charlottesville □ Waynesboro

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		PATIENT	NAME(S)		
Name		DOB	Pr	eferred Name	Gender 🗆 M 🗆 F
Name		DOB	Pr	eferred Name	Gender 🗆 M 🗆 F
Name		DOB	Pr	eferred Name	Gender 🗆 M 🗆 F
Name		DOB	Pr	eferred Name	Gender 🗆 M 🗆 F
Patient A	.ddress				
With who	om does the patient live?				
Who may	y we thank for referring you to our practice?				
	PARENT / LEGAL GUARDIAN 1			PARENT / LEGA	L GUARDIAN 2
	Specify relation:		Spe	ecify relation:	
Nama			Nama		
	Home				
THORICS	Mobile		THORICS		
	Work				
E-mail			E-mail		
Address			Address		
	☐ Address same as patient			☐ Address same as patier	nt
Employe	r		Employe		
. ,	DOB		, ,		DOB
	CONSENT BY PROXY	FOR DIAGN	NOSTIC AI	ID PREVENTIVE CARE	
	st any individuals (other than a parent or legal guardia anings, fluoride, etc.).	n) that may l	bring your	child(ren) to their <u>routine</u> dei	ntal appointments (e.g., exams, X-
protected	vidual(s) listed below must be an adult (18+) and led patient health information may be shared with the properties the appointment may be rescheduled and treated as a	oxy to facilit			
Proxy Na	ame		Relation t	o Patient	
Proxy Na	ame		Relation t	o Patient	
Proxy Na	ame		Relation t	o Patient	
Please N	lote: A parent or legal guardian must consent to and b	ne present fo	r all other s	services (e.g., surgical, resto	prative, emergency, etc.)

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. In case of an emergency requiring an after hours appointment, an additional fee (payable in cash on the date of service) will be charged in addition to the normal cost of services rendered.

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 90 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 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.

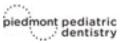
<u>I understand that this office has a strict 48-hour cancellation/no-show policy.</u> Unforeseen circumstances do occur and sometimes require missing an appointment; however, if an appointment is missed without proper notice, we have policies in place to protect the appointment times for your child and other children that need care. Failure to provide proper notice for Recall appointments may result in a \$40 fee and for Restorative/Surgical appointments in our Waynesboro location may 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 may be 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  $\Box$ .

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 ob	tain written Acknowledgment of Receipt of Notice of Privacy P	<i>'</i>					



## **HEALTH HISTORY**

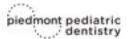
Practice Location:

☐ Charlottesville ☐ Waynesboro

	ΡΔ	 ΓΙΕΝΤ				
Name	DOB					
Preferred Name	Age					
	MEDICAL	CONDITIONS				
Please indicate any current or past me						
□ ADD/ADHD	□ Eating Disorder	□ Psvch	iatric Disorder			
□ Anemia	□ Eczema	,	□ Anxiety/Panic			
□ Aspergers	□ Epilepsy / Seizure	S	□ Bipolar Disorder			
□ Asthma	□ Hearing Disorder		□ Depression			
☐ Autism Spectrum Disorder	□ Heart Defect / Mu	rmur	□ Other			
□ Birth Defect	☐ Heart Disease	□ Obesi	□ Obesity			
□ Blood Disorders	□ Hepatitis	□ ODD				
□ Cancer	□ High Blood Press	ure □ Respir	ratory Problems			
□ Cerebral Palsy	☐ History of Abuse	□ Rheumatic Fever / Rheumatism				
□ Cleft Lip and/or Palate	□ HIV/AIDS	☐ Sickle Cell ☐ Disease ☐ Trait				
☐ Cognitive Impairment	□ Jaundice		□ Sinus Problems			
□ Developmentally Delayed	□ Kidney Disease	□ Syndr				
☐ Diabetes ☐ Type 1 ☐ Type 2	<ul> <li>Learning Disability</li> </ul>		h Disorder/Delay			
□ Down Syndrome	□ Liver Disease	•	d Disorder			
☐ Genetic Disorder	□ Migrane Headach					
□ GERD	□ Pregnancy		Disorder			
<u>_</u>	□ Premature Birth		/ Not Listed (specify below)			
If YES to any condition above, please	explain:					
☐ The patient has never been diagn	osed with any condition, includ	ing those listed above.				
	HOSPITALIZATIONS AND	SURGERIES / PROCEDURES				
□ Adenoidectomy	Date:	□ Tonsillectomy	Date:			
- Additional Control of the Control		2 Tollomostolli,	<u> </u>			
□ Ear Tubes	Date(s):	Dental Surgery under:				
□ Eye Surgery	Date(s):	□ General Anesthesia	Date(s):			
Lye Surgery	Date(s).	acricial Ariestricsia	Date(3)			
☐ Heart Surgery (specify below)	Date(s):	☐ Sedation (e.g. oral, IV)	Date(s):			
Other currenties presedures and/or or	novacancias with data(s).					
Other surgeries, procedures, and/or er	nergencies with date(s).					
☐ The patient has not been hospita	lized or had any surgeries.					
	ALI	ERGIES				
Specify drug allergies and reaction(s):						
Specify environmental / food allergens	and reaction(s):					
☐ The patient has no allergies.						
	MEDI	CATIONS				
Please list all of the patient's current m	edication(s) and/or supplements:					
· · · · · · · · · · · · · · · · · · ·						
☐ The patient does not take any medications.						
•						
INTERNAL OFFICE USE: Fluoride	applied today: ☐ Y ☐	N Tx updated in system	: □ Y □ N/A			

Next Visit: \_\_\_

X-rays taken: \_\_\_\_



## **DENTAL HISTORY**

INITIAL VISIT							
What is your primary concern about your child's oral health?							
Management and the second and Electrical Andrea							
May your child have the recommended Fluoride today?		□ Y	□ N				
May your child have any recommended X-rays today?		□ Y	□ N				
GENERAL							
Is this the patient's first dental visit? $\square$ Y $\square$ 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?	□Υ	$\square$ N				
If YES, explain							
Does/did the patient have any oral habit(s) after one year of	age?	□Υ	□N	If YES, until what age?			
				<ul><li>☐ Finger/Thumbsucking</li><li>☐ Pacifier</li><li>☐ Bottle, Sippycup</li><li>☐ Other</li></ul>			
	OR	AL HYGIE	ENE				
Who brushes the patient's teeth?	How ofte	en are the	patient's t	teeth brushed? times per			
Does someone regularly assist? ☐ Y ☐ N	If YES, w	/ES, who					
Who flosses the patient's teeth?	How ofte	en are the	patient's t	teeth flossed?   Daily  Occasionall	y 🗆 Never		
Does someone regularly assist? ☐ Y ☐ N	If YES, w	/ho					
Does the patient's toothpaste contain fluoride?	$\square$ N						
		DIET					
Is the patient's drinking water fluoridated?	□ Y	$\square$ N	Water S	ource □ City/Municipal □ Well □	□ Bottled		
Is the patient receiving supplemental fluoride in any form?	□Y	□N		ent Type(s)			
Does your child eat or drink after bedtime brushing?	□Y	□N		ist			
Does your child have a diet high in sugars or starches?  Do you have any concerns about your child's weight?	□ Y □ Y	□ N □ N		describedescribe			
How frequently does your child have the following?		□ IN	II ILO, C	uescribe			
Candy or other sweets ☐ Rarely ☐ 1-2 tin	nes/day	□ 3+ tin	nes/day	Product			
Chewing Gum □ Rarely □ 1-2 times/day		•					
Snacks between meals   Rarely   1-2 times/day				nack	Sweet		
Drinks * □ Rarely □ 1-2 times/day □ 3+ tim juices, fruit-flavored drinks, sodas, colas, carbonated bever	•		everages,		Note: e.g.		
DENTAL EXPERIENCE							
How do you expect your shild to react to dontal tractice and							
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)?							
If YES, explain							
To the best of my knowledge the information provided o staff of Piedmont Pediatric Dentistry to perform and pro			-				

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