piedmont pediatric dentistry

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Pediatric Dentist

# COVID-19 Prescreening Form

**Patient Name:** _____ **Date of Birth:** _____

1. Does the patient or anyone in their household have a fever? □ Yes □ No
2. Does the patient or anyone in their household have any shortness of breath? □ Yes □ No
3. Does the patient or anyone in their household have a dry cough? □ Yes □ No
4. Has the patient or anyone in their household recently experienced loss of taste or smell? □ Yes □ No
5. Has the patient or anyone in their household have any other flu-like symptoms (e.g., fatigue, headache/bodyaches, diarrhea, etc.)?

   □ Yes □ No If Yes, please describe: _____
6. Has the patient or anyone in their household had any contact with any confirmed COVID-19 positive people?

   □ Yes □ No If Yes, please describe: _____
7. In the last 14 days, has the patient or anyone in their household traveled to a high-risk area?

   □ Yes □ No If Yes, please describe: _____

**COVID-19 Pandemic Dental Treatment Notice and Acknowledgement of Risk**

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Some dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. A protective mask cannot be worn over the mouth to reduce exposure during treatment as your healthcare providers need access to the mouth to render care. This leaves vulnerability to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

**Patient Acknowledgement**

- I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.
- I understand and accept the increased risk of COVID-19 exposure with treatment at this office.
- I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.
- I acknowledge that if the patient, anyone in their household, and/or the person bringing the patient to their appointment answers YES to any of the questions on the COVID-19 Prescreening Form, you may be asked to reschedule.

**My signature below indicates that I have read and understand the information stated above.**

_____ _____
Signature Printed Name

_____ _____
Relationship to Patient Date

*Revised 5/22/2020*

240 Hydraulic Ridge Road, Suite 203
Charlottesville, VA 22901
**T** 434 973 4344
**F** 434 973 4675

2520 West Main Street
Waynesboro, VA 22980
**T** 540 943 3315
**F** 540 973 1772

www.piedmontpd.com

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# NEW PATIENT FORM

Practice Location:
☐ Charlottesville ☐ Waynesboro

## PATIENT NAME(S)

Name _____ DOB _____ Preferred Name _____ Gender ☐ M ☐ F

Name _____ DOB _____ Preferred Name _____ Gender ☐ M ☐ F

Name _____ DOB _____ Preferred Name _____ Gender ☐ M ☐ F

Name _____ DOB _____ Preferred Name _____ Gender ☐ M ☐ F

Patient Address _____

_____

With whom does the patient live? _____

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

## PARENT / LEGAL GUARDIAN 1

*Specify relation:* _____

Name _____

Phones Home _____

Mobile _____

Work _____

E-mail _____

Address

☐ Address same as patient

_____

_____

Employer _____

SSN _____ DOB _____

## PARENT / LEGAL GUARDIAN 2

*Specify relation:* _____

Name _____

Phones Home _____

Mobile _____

Work _____

E-mail _____

Address

☐ Address same as patient

_____

_____

Employer _____

SSN _____ DOB _____

## CONSENT BY PROXY FOR DIAGNOSTIC AND PREVENTIVE CARE

*Please list any individuals (other than a parent or legal guardian) that may bring your child(ren) to their routine dental appointments (e.g., exams, X-rays, cleanings, fluoride, etc.).*

The individual(s) listed below must be an adult (18+) and 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. If an unauthorized person accompanies the patient, the appointment may be rescheduled and treated as a "No Show".

Proxy Name _____ Relation to Patient _____

Proxy Name _____ Relation to Patient _____

Proxy Name _____ Relation to Patient _____

*Please Note*: *A parent or legal guardian must consent to and be present for all other services (e.g., surgical, restorative, emergency, etc.)*

## CONSENT FOR DENTAL TREATMENT

Version 12202018

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.

I understand that this office has a strict 48-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 may 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 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 □.

**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): _____

_____

☐ **The patient has not been hospitalized or had any surgeries.**

## ALLERGIES

Specify drug allergies and reaction(s): _____

_____

Specify environmental / food allergens and reaction(s): _____

_____

☐ **The patient has no allergies.**

## MEDICATIONS

Please list all of the patient's current medication(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

X-rays taken: _____ Next Visit: _____

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# DENTAL HISTORY

## INITIAL VISIT

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

_____

**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? ☐ 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**