Today's Date ____________________

Child's Information				
Last Name	**First Name**	**Middle Initial**	**Preferred Name**	□ **Male** □ **Female**
Date of Birth	**Home Address**			
Who has legal custody of the child?			**Referred by**	

Mother's Information				
Last Name	**First Name**	**Middle Initial**	**Best Contact #:**	**Email Address:**
Date of Birth	**SSN**	□ **Same as child's**	**Home Address**	
Marital Status: □ **Single** □ **Married** □ **Responsible for account**	□**Separated**	□**Widowed** **Employer:**	□**Divorced**	

Father's Information				
Last Name	**First Name**	**Middle Initial**	**Best Contact #:**	**Email Address:**
Date of Birth	**SSN**	□ **Same as child's**	**Home Address**	
Marital Status: □ **Single** □ **Married** □ **Responsible for account**	□**Separated**	□**Widowed** **Employer:**	□**Divorced**	

Who is accompanying the child today?		
□ Mom	□ Dad	Other:

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I am the parent, guardian, or personal representation of the child listed above and there are no court orders in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I certify that my dependent is covered by the insurance listed above and assign directly to Gainesville Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Gainesville Pediatric Dentistry may use my child's health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services.

In the event that I am unable to bring my child in for an appointment, the following individuals have my permission to accompany my child, as well as make any necessary decisions for my child's care. This includes consenting to any necessary treatment. **IMPORTANT**: **The legal guardian must accompany their child/children for the first appointment and sedation appointments.**

NAME and RELATIONSHIP TO PATIENT: CONTACT NUMBER:

___________________________ ___________________ ______________________

Parent/Guardian Signature: ____ **Date:** _______________________

Our Late Policy

**** If you are more than 10 minutes late to your appointment, we reserve the right to cancel or reschedule your appointment. ****

PEDIATRIC MEDICAL HISTORY

CHILD'S PRIMARY CARE PHYSICIAN PHONE

PRACTICE NAME AND LOCATION

IS YOUR CHILD CURRENTLY UNDER A PHYSICIAN'S CARE FOR ANY MEDICAL, EMOTIONAL, OR BEHAVIORAL CONDITIONS?

Was your child born prematurely?	Y	N	
Did your child spend time in the Neonatal ICU?	Y	N	
Has your child had surgery?	Y	N	List Surgeries: ___________________
Has your child ever been hospitalized?	Y	N	If so, why?: _____________________
Any prescriptions or OTC medications?	Y	N	List Medications: ________________
Does your child have any allergies?	Y	N	List Allergies: ____________________
Are your child's immunizations up to date?	Y	N	

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

ADD/ADHD	Eating Disorder	HIV/AIDS	Tuberculosis
Anemia	Emotional Disorder	Hydrocephalus	Developmental
Artificial Joints	Endocrine Disorder	Kidney Disease	Disabilities:
Asthma/Lung Disease	Epilepsy/Seizures	Liver Disease	__________________
Autism- Minor/Severe	Gastrointestinal/Digestive Problem	Rheumatic Fever	__________________
Bleeding Disorder/Hemophilia	Hearing/Speech Problems	Sickle Cell Disease/Trait	Other: ______________
Cancer	Heart Disease/Defect/Murmur	Sleep Disorder/Snoring	__________________
Cleft Palate/Lip	Pre Med required: Y N	Stroke/Aneurysm	**□ My child has**
Diabetes	Hepatitis	Thyroid Conditions	**none of the above**

Please use the space below if needed:

____

____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
GAINESVILLE PEDIATRIC DENTISTRY

13555 Wellington Center Circle Suite #105
Gainesville, VA 20155
703-754-1580

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used, or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that when contacting me about my appointments, Gainesville Pediatric Dentistry will leave the name(s) of my child(ren) on my machine, but no other information will be left in order to secure my family's privacy.

Preferred number for messages :(________) ______________________________________

Patient(s) name: ____

Your Relationship to patient(s): ____

Parent's Signature: ____ Date:___________________

24 Hour Cancellation Policy

Gainesville Pediatric Dentistry has a strict 24-hour cancellation policy in the event you are unable to make your appointment. This allows us the opportunity to schedule another patient in need of dental care. If you fail to cancel your child/children's appointments within the 24 hour policy, our office reserves the right to charge **a $25 missed appointment fee per child** or $50 family max for multiple children.

I have read and understand the 24 hour cancellation policy.

Patient(s) Name: ____

Parent's Signature: ____

Gainesville Pediatric Dentistry: Financial Policy

Thank you for choosing us as your child's dental health care provider. We are committed to your child's treatment being successfully completed. Please read and sign our financial policy. The person responsible for the account (as listed on the patient information form) is the person required to sign our financial policy. This person is legally responsible for the payment of all charges. Statements cannot be sent to other parties. Payment is requested at each appointment.

WE REQUIRE PAYMENT IN FULL AT THE TIME OF SERVICE.
We accept Cash, Check (Verified by TeleCheck), Visa, MasterCard, American Express, Discover or CareCredit.

Our office is a Preferred Provider for the following insurance companies:

1. Delta Dental (PPO only)
2. Virginia Medicaid (Smiles for Children)
3. Metlife (PPO only)
4. United Concordia (Tricare/Active Military only)

If you have any of the insurance companies and plans listed above, you are not required to pay in full today. We will collect from you the estimated amount insurance is not expected to pay (co-insurance, co-payments, etc.) We will submit your claim and should there be a balance we will bill you for the remainder of what your insurance does not cover. Payment is expected within 30 days of the billing statement.

If you have another dental insurance please bring your insurance information with you to your appointment. If we have received all your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. We will submit your claim and should there be a balance we will bill you for the remainder of what your insurance plan does not cover. Payment is expected within 30 days of the billing statement. Should you have an HMO, DHMO or POS plan, please be aware that we do not accept these plans, nor do we file the claims for you. Therefore, payment is due at the time services are rendered.

Please note that insurance is a contract between you and your insurance company. We are not a part of that contract. We will not become involved in a dispute between you and your insurance company regarding deductibles, co-payments, covered or non-covered charges, "usual and customary" charges, etc. other than to supply factual information regarding services rendered. If you have any questions regarding why the insurance covered a certain amount, please address them to your insurance company.

Exceptions
Should you have any of the following insurance companies, please be aware that we do not work with any of their plans, PPO or HMO and we do require payment in full at the time services are rendered. We will provide you with a statement of services rendered for you to submit to your insurance company for your direct reimbursement.

1. Blue Cross/Blue Shield

Payment Plans
If your child should require extensive dental treatment and you have concerns regarding **financial responsibility**, we recommend **preauthorizing** the treatment to your insurance company for an accurate indication of *out of pocket* expenses. In addition, we also accept CareCredit, which is a convenient, low minimum monthly payment program specifically designed to pay for health care services.

Overdue Balance
You are ultimately responsible for any balance on your account. If you have not paid your balance within 60 days of receipt of an invoice, a $5 billing charge will be added each month until resolved. Any balance remaining unpaid for 90 days or more will receive a final notice letter before being sent to collections. In the event that your account is sent to collections, you will be responsible for any and all costs incurred in the collection of this debt. This includes: an interest rate of 1.5% of the unpaid balance from the last date of service, attorney fees and court costs.
I have read, understood and agree to abide by this financial policy.

Signature: ____ Date: ___________________

Consent for Use or Disclosure of Patient's Protected Health Information
(HIPAA)

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

PATIENT(S) NAME: ____

DATE OF BIRTH(S) :____________________________________(for identification purposes)

***The below information gives our office consent to release your child's dental records including x-rays, health history and insurance information. We will only release this information to another dental office that your child is also a patient at such as: Orthodontist, Oral Surgeon, Endodontist or any other dental related office.**

*I hereby authorize **Gainesville Pediatric Dentistry** to release the following personal health information for:

☐ Dental service claims information

☐ Prescription, diagnostic, treatment, and/or care management services

The above information may be released by:

☐ Phone ☐ Mail ☐ E-mail ☐ Fax

My Consent:

Effective: Today's Date ____

I want this consent to:

☐ Continue Indefinitely ☐ Effective Only Until ________________________________(date)

*I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices. (If you wish to review the entire Notice of Privacy Practices please ask the front desk.)

Signature of Patient 18+: ____ Date ______________

*If patient is a minor:

Legal Guardian or Parent Signature: ________________________________ Date ______________

Patients 18+ ONLY

I __________________________ authorize Gainesville Pediatric Dentistry to release my dental/ Medical information to the following person:

Please print name:

1.____ Relationship: ______________________________

2.____ Relationship: ______________________________

3.____ Relationship:_______________________________

Signature of patient age 18+:____