Welcome to our Practice!

We strive to make your child's visit pleasant and comfortable. Our goal is to teach your child oral habits that will keep his/her smile beautiful for a lifetime.

DATE: _____/ _____/ _____
MM DD YY

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____ Nickname: _____

Age: _____ Date of Birth: _____/ _____/ _____ Male☐ Female☐ School: _____ Grade: _____

Permanent Address _____ City _____ State _____ Zip _____

►Whom may we thank for referring you to our practice? _____

PARENT/GUARDIAN INFORMATION

Parents' Marital Status: Married☐ Divorced☐ Single☐ Separated☐ Widowed☐

►MOTHER☐ FATHER☐ STEPMOTHER☐ GUARDIAN☐

Last Name: _____ First Name: _____ Date of Birth: _____/ _____/ _____

SSN: _____ - _____ - _____ Employer: _____Work # (_____) _____ - _____

Address (if different than patient) _____

Home # (_____) _____ - _____ Cell # (_____) _____ - _____ Email _____

► MOTHER☐ FATHER☐ STEPFATHER☐ GUARDIAN☐

Last Name: _____ First Name: _____ Date of Birth: _____/ _____/ _____

SSN: _____ - _____ - _____ Employer: _____ Work # (_____) _____ - _____

Address (if different than patient) _____

Home # (_____) _____ - _____ Cell # (_____) _____ - _____ Email _____

PRIMARY DENTAL INSURANCE

Dental Insurance Company Name: _____ Group # _____

Insurance Subscriber's/Policy holder's Name: _____ Relationship to child: _____

Date of Birth: _____/ _____/ _____ SSN: _____-_____-_____ Subscriber/Policy Holder # _____

Employer: _____

SECONDARY DENTAL INSURANCE (IF APPLICABLE)

Dental Insurance Company Name: _____ Group # _____

Insurance Subscriber's/Policy holder's Name: _____ Relationship to child: _____

Date of Birth: _____/ _____/ _____ SSN: _____-_____-_____ Subscriber/Policy Holder # _____

Employer: _____

HEALTH HISTORY

Your child's overall health and any medication that he/she takes could have an important interrelationship with the dental care he/she receives. ***Please answer each of the following questions completely.***

▪ Has your child had difficulty with previous dental visits? Yes☐ No☐ If yes, please explain: _____

_____

▪ Has your child been hospitalized? Yes☐ No☐ If yes, please explain: _____

_____

▪ Is your child allergic to or made sick by penicillin, aspirin, codeine, or any other medications? Yes☐ No☐

If yes, please list: _____

▪ Has your child had a history of problems with any of the following? (***Check all that apply***)

☐ **ADHD**	☐ **Cerebral Palsy**	☐ **Heart Murmur**	☐ **Psychiatric Problems**
☐ **Allergies**	☐ **Congenital Heart Defect**	☐ **Heart Surgery**	☐ **Rheumatic Fever**
☐ **Anemia**	☐ **Depression**	☐ **Hemophilia**	☐ **Sickle Cell Disease**
☐ **Anxiety**	☐ **Developmental Delay**	☐ **Hepatitis**	☐ **Stroke**
☐ **Artificial Heart Valve**	☐ **Diabetes**	☐ **High Blood Pressure**	☐ **Thyroid**
☐ **Artificial Joint**	☐ **Down Syndrome**	☐ **Hospitalization**	☐ **Tuberculosis**
☐ **Autism Spectrum Disorder**	☐ **Epilepsy/Seizures**	☐ **Kidney Problems**	☐ **Wheelchair Bound**
☐ **Asthma**	☐ **Fainting Spells**	☐ **Mitral Valve Prolapse**	☐ **Other?**_____
☐ **Blood Transfusion**	☐ **Fever Blisters**	☐ **Organ Transplant**	_____
☐ **Cancer-Chemotherapy**	☐ **Frequent Headaches**	☐ **Pain In Jaw Joints**	_____
	☐ **HIV+/AIDS**		

▪ Please list any medical conditions, diseases, or problems that your child has if it is not listed above: _____

_____

▪ Please list any medications your child is currently taking: _____

▪ Name of Child's Physician: _____

►CHILD'S HABITS

▪ When was your child's last dental visit? _____/ _____/ _____ What was the name of your child's dentist? _____

▪ How often does your child brush his/her teeth? _____ x per day

▫ Does your child take fluoride supplements?	Yes☐ No☐	▫ Is your child currently breast fed?	Yes☐ No☐
▫ Does your child use a sippy cup?	Yes☐ No☐	▫ Does your child sleep with a bottle?	Yes☐ No☐
▫ Does your child suck his/her thumb or finger(s)?	Yes☐ No☐	▫ Does your child use a pacifier?	Yes☐ No☐
▫ Does your child grind his/her teeth?	Yes☐ No☐	▫ Does your child chew hard objects (pencils etc.)?	Yes☐ No☐

Authorization and Release

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child during the period of dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

►**SIGNATURE OF PARENT/GUARDIAN** _____ **DATE** _____/ _____/ _____
MM DD YY

FINANCIAL AND GUARANTOR AGREEMENT

PLEASE READ CAREFULLY!

►FEES, PAYMENTS AND INSURANCE

- We are a fee for service practice and payment is expected at the time of service.
- The parent bringing the child to the dentist is the responsible party for payment. Please come prepared with your payment as we will not bill any other party for services rendered.
- If you have insurance, please be advised that your ESTIMATED copayment is DUE at the time of your child's dental visit. **Remember your insurance policy is an agreement between you and the insurance company.** *Our practice is not a part to that agreement*.

►24 HOUR NOTICE POLICY

- **In the unlikely event you are unable to come at your appointed time, please notify us within 24 hours of your appointment.**
- Two or more missed appointments or untimely cancellations will result in the termination of your child's dental care in our office.

►MISCELLANEOUS

- All paperwork, including medical history, patient information and consent forms, must be completed by parent or legal guardian.
- **Pre-sedated and pre-school age patients will be appointed between the hours of 8AM and 12 NOON.**
- Due to space limitations, when you are accompanied by other children who do not have dental appointments, please remain in the waiting room with those children.

●● I have read and fully understand the above Financial and Guarantor Agreement and accept all provisions. I am also aware that by signing below I am financially responsible for this account.

►**SIGNATURE OF PARENT/GUARDIAN** _____ **DATE** ____/ ____/ ____
MM DD YY

Eastern Virginia Pediatric Dentistry

A Division of Atlantic Dental Care, PLC
1806 Hampton Blvd, Suite A
Norfolk, VA 23517
(757)627-7550

FINANCIAL AGREEMENT

DENTAL INSURANCE As a courtesy, we will be happy to help you file your insurance claims. You must provide us with all the information necessary to verify your child's eligibility and to file your claim. **Remember your insurance policy is an agreement between you and the insurance company.** *Our practice is not a part to that agreement*. Though we may estimate your insurance benefits, we are not responsible for its accuracy. Knowledge of benefits, as well as benefit amounts, limitations, exclusions, waiting periods, etc. is ***your*** responsibility. Receiving our services indicates acceptance of responsibility to pay regardless of our estimate. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits *differ* from one insurance company to another. Fees for non-covered services, including deductibles and copayments, are due at the time of service. We can file a pre-determination for recommended treatment. We strongly suggest that you contact your insurance company with any questions you may have. Again, we will help file your insurance as a courtesy to you.

PAYMENT We accept cash, check, Visa, MasterCard, Discover, and American Express. By law your insurance company is required to pay each claim within 30 days. After dental insurance has paid its portion, a statement for the remaining balance will be sent to your mailing address on record. *If payment is not made upon receipt of our statement,* ***we will no longer file your insurance and expect payment in full at the next time of service.*** If we have not received payment from your insurance company 60 days after services are rendered, you will be responsible for the full account balance.

MONTHLY STATEMENT If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; **we cannot send statements to other persons.**

COLLECTION POLICY If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

MINOR PATIENTS The parent or guardian accompanying the minor is responsible for the full payment. In the case of *divorced* or *separated* parents, the parent accompanying the child is responsible for payment. This office will not attempt to collect payment from a parent that is not present in the office at that visit. If the divorce decree requires the other parents to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS FINANCIAL AGREEMENT.

_____

PATIENT(S) NAME(S)

_____

PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (PRINTED)

_____

PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (SIGNATURE)

RELATIONSHIP TO PATIENT(S) _____ DATE _____/_____/_____
MM DD YY

Eastern Virginia Pediatric Dentistry A Division of Atlantic Dental Care, PLC
CONSENT FOR DENTAL TREATMENT

Patient _____

1. I request and authorize Dr. Morgan and staff to perform or assist in the performance of the following but not necessarily limited to:

    - Emergency Dental Treatment
    - Fillings
    - Cleanings, X-rays, Fluoride treatments
    - Sealants
    - Extractions/Oral Surgery
    - Space Maintenance/Interceptive Orthodontics
    - Crowns

2. The purpose of the above is to maintain dental health and we anticipate that result. No guarantees or assurances can be made as to the results that may be obtained.

3. Bleeding, swelling, discomfort and bruising can occur after any dental procedure. The risk of not completing necessary dental treatment can result in abscess, infection, pain, fever, swelling and substantial risk to the developing permanent teeth.

4. I understand that unforeseen conditions or circumstances may arise during the course of the above-described procedure or treatment. Hence, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist reasonably believes necessary or advisable as a result of these unforeseen events.

5. I understand that to facilitate my child's treatment a sedative may be required. I understand that sedation may prove partially or completely ineffective.

6. Additionally, I consent to the administration of local anesthetic that the dentist deems necessary, and/or nitrous oxide. I understand that the risks involved with the administration or local anesthetics may also be characterized by excitation, depression, nervousness, dizziness, blurred vision, tremors, drowsiness, and convulsions (seizures). Allergic reactions may occur which may be characterized by skin eruptions, itching, and swelling. I understand that the alternative of not using local anesthetic would probably cause a great deal of discomfort. The risk of this alternative could be emotional damage.

7. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand that treatment in terms appropriate for their age. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

8. **I understand that I may refuse any and all treatments**. I have crossed out and initialed anything that I would refuse to consent to.

9. I certify that I have read and understand the above. I accept the risk of substantial and serious harm, if any, in hope of obtaining the desired beneficial results of this treatment or procedure

10. I understand that I am responsible for all fees incurred in relation to this child. This office will also assist in the prompt filing of all insurance forms as it applies.

_____

PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (SIGNATURE)

RELATIONSHIP TO PATIENT(S) _____ DATE _____/_____/_____

MM DD YY

Eastern Virginia Pediatric Dentistry

A Division of Atlantic Dental Care, PLC
1806 Hampton Boulevard, Suite A ● Norfolk, Virginia 23517
757.627.7550

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give us this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 15, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION ("You" implies your child or children)

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you make revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare of with payment for you healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for you care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, text messages, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will you $0.__ for each page, $___ per hour for staff to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure or your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

OFFICE MANAGER OR HER DESIGNEE
Telephone: **757.627.7550** Fax: **757.627.2634**
Address: **1806 Hampton Boulevard, Suite A, Norfolk, VA 23517**

Eastern Virginia Pediatric Dentistry

A Division of Atlantic Dental Care, PLC

1806 Hampton Boulevard, Suite A ● Norfolk, Virginia 23517
757.627.7550

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

_____