

WELCOME

1

About Your Child

Today's Date: ___/___/___ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ Boy Girl

Child's Birthdate: ___/___/___ Age: _____

School: _____ Grade: _____

Child's Home Phone #: (_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

2

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? Yes No
Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3

Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? _____ Age(s): _____

MOTHER'S NAME STEP MOTHER GUARDIAN EMAIL ADDRESS

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) (_____)
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

FATHER'S NAME STEP FATHER GUARDIAN EMAIL ADDRESS

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) (_____)
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

4

Account Information

Person ultimately responsible for account

Name: _____ RELATION TO CHILD

Billing Address: _____

CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____) (_____)
WORK PHONE #: EXT. CELL PHONE #:

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

5

Child's Dental Information

Reason for today's visit: Exam Emergency Consultation

Is Child in pain? No Yes How Long? _____

Please indicate any of the following problems:

- Discomfort, clicking or popping in jaw. Lost/Broken Filling(s) Stained teeth
- Red, swollen or bleeding gums. Teeth grinding Locking Jaw
- Sensitive tooth, teeth or gums. Ringing in Ears Bad breath
- Blisters/Sores in or around the mouth. Broken/Chipped tooth Loose tooth
- Other(s): _____

Does child require pre-medication? Yes No Don't know

Previous Dentist: _____ (_____) _____

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? Yes No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

6

Child's Medical History

Is Child taking any of the following medications? Pain killers (INCLUDING ASPIRIN) Ritalin Stimulants
 Blood Thinners Tranquilizers Insulin Muscle relaxers Others: _____

Child's Physician: _____ (_____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE#

Last Medical Exam: ____ / ____ / ____

ADDRESS CITY STATE ZIP
Does Child have or ever had any of the following diseases, medical conditions or procedures?

- | | | |
|------------------------------------|--|---|
| Y N Heart Murmur | Y N Tonsillitis | Y N High/Low Blood Pressure |
| Y N Rheumatic fever | Y N Respiratory Problems | Y N Hepatitis |
| Y N Artificial Heart Valves | Y N Asthma/Difficulty Breathing | Y N Artificial Bones/Joints/Implants |
| Y N Congenital Heart defect | Y N Blood Transfusion(s) | Y N Liver/Kidney/Organ Problems |
| Y N Scarlet Fever | Y N Leukemia/Anemia | Y N HIV+/AIDS/ARC |
| Y N Surgeries/Operations | Y N Diabetes/Hypoglycemia | Y N Tuberculosis TB |
| Y N Cancer/Tumors | Y N Hemophilia | Y N Psychiatric Problems |
| Y N Chemotherapy | Y N Abnormal Bleeding | Y N Hyper Active/ADD |
| Y N Jaw Problems TMJ/TMD | Y N Cleft Lip/Palate | Y N Fainting/Seizures/Epilepsy |
| Y N Hearing Problems | Y N Birth Defects | Y N Cerebral Palsy |

Please list any other medical condition(s) child has or ever had: _____

Is Child allergic to: Latex Penicillin/Amoxicillin Tetracycline Dental Anesthetics (Novocaine)
 Aspirin Food allergies Other(s): _____

Please rate the child's general health from 1-10: _____ Does child wear contact lenses? Yes No

Has this child ever taken the drug Ritalin? No Yes/How long? _____ Child's Blood type: _____

Does this child do any of the following? Thumb/Finger Sucking Tongue Thrusting/Sucking
 Heavy Snoring Mouth Breathing Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____
 Parent or Guardian Other:

UPDATE (OFFICE USE)

Initials _____ / _____ / _____
Date

Comments

Initials _____ / _____ / _____
Date

Comments

Initials _____ / _____ / _____
Date

Comments

Michael Polifko, DDS
Mary Catherine Dvorak, DDS
2010-D Opitz Boulevard
Woodbridge, VA 22191
P: (703)494-6690 F: (703)494-9600

Welcome to our Practice!

Thank you for choosing our office for your dental health needs. We would like to acquaint you with our office policies. It is our goal to provide quality dentistry within a caring and friendly environment. We hope that you and your family feel welcome here.

Dental Insurance

Our practice is currently in network (participating) with United Concordia and MetLife. However, we do accept all PPO policies. Due to our out of network (non-participating) status, you may be required to pay for your visit in full and be reimbursed by your insurance. As a courtesy we will file your insurance claims for you to expedite your reimbursement. There may be times when we are unable to file on your behalf; in these cases we will provide you the appropriate forms to file. We **do not** accept HMO, DMO, Medicaid or Medicare insurance. Any non-covered service or portion of any services not paid by your insurance is due at time of service. Any insurance claims not paid by your insurance company within 45 days will become your responsibility in full. All dental policies differ in coverage; please refer to your individual policy for details.

X-Ray Transfer

Please request any current x-rays be sent to our office. Current x-rays are bitewings less than 1 year and full mouth series (FMX) and/or panorex less than 3 years old. These x-rays are needed to provide you with the best dental care possible. If we do not have recent x-rays it will be necessary for us to take the needed x-rays. Due to insurance guidelines, new x-rays taken before their due date will not be covered.

Cancellations and Broken Appointments

We realize that emergencies occur and it is not always possible to give us 48 hour notice for an appointment that you are unable to keep. **We do take this into consideration, however, we do reserve the right to charge a minimum of \$50.00 for appointments broken without 48 hour notice.** This policy allows us to schedule another patient in need of dental care.

OSHA/HIPPA

You will be asked to review and update your medical history on an annual basis to notify us of any changes. We have a legal obligation to keep your information private. Such updates enable us to provide you with safe dental care. If you refuse to update the forms, we reserve the right to refuse treatment.

Section 32 1-23(A) and (B) Code of VA (1950), as amended) provides that, in the event of significant exposure (e.g. needle stick) consent for testing for Human Immunodeficiency Virus (HIV) and Hepatitis will be given by the patient and/or the healthcare worker. Test results are confidential and can only be released in accordance with applicable laws and the policy of the testing facility.

Authorization

I authorize the release of information and payment of my dental benefits to the dentist. I have read and understand the above policies regarding insurance and financial agreements. I also understand that in the event my account becomes delinquent, I will be responsible for any collections, attorney's fees and court costs, including any other charges incurred to collect payment for my account.

Signature: _____

Date: _____

Michael Polifko, DDS
Mary Catherine Dvorak, DDS
2010-D Opitz Boulevard
Woodbridge, Virginia 22191
(703) 494-6690

X-ray Policy Information

In order to provide our patients with the best care possible, certain x-rays are required. Such x-rays do carry frequency limitations with insurance companies. If you have a history of the following, we do ask that you request copies from your previous Dentist.

- Bitewing x-rays within the last 12 month
- Full mouth or Panoramic x-rays within the last 5 years

Prior to your first visit with us we will verify your x-ray history thru the insurance information you provide to us, provided there is adequate time before you are seen.

In the event you are not eligible for the required x-rays and are not able to obtain copies prior to your initial visit, it will be necessary for us to take new films at your cost or reschedule your appointment until such time that x-rays become obtainable.

If you have any questions for any reason, please call our office and a member of our staff will be happy to help you.

We look forward to caring for all your dental needs.

Respectfully yours,

Dr. Michael Polifko, DDS & Dr. Mary Catherine Dvorak, DDS

Patient Name: _____
(Print)

Relationship to Patient: _____

Signature: _____

Date: _____

Michael Polifko, DDS
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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct, or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (*e.g.*, my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *NOTICE of PRIVACY PRACTICES* which contains a more complete description of the uses and disclosures of my protected health information and my rights under *HIPAA*. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use of disclosure that occurred prior to the date that I revoke this consent is not affected.

Patient Name: _____ Relationship to Patient: _____
(print)

Signature: _____ Date: _____