Kingstowne Pediatric Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions we'll be happy to help. We look forward to working with you to maintain your child's dental health.

1. Tell Us About Your Child

Child's Name_____
Last First MI

Nickname _____ ❑ Male ❑Female

Child's Birthdate_____/_____/_____ Child's Age _____

Child's Home # (_____)_____

Child's Home Address_____

_____

Referred by_____

2. Mother's Information

Name _____

Birthdate _____/_____/_____ ❑Stepmother ❑ Guardian

Employer_____

Work # (_____)_____

Home # (_____)_____

Cell # (_____)_____

SS #_____

E-mail Address:_____

Marital Status ❑ Single ❑Married ❑ Separated

❑ Widowed ❑Divorced

Active duty military at this time? ❑Yes ❑No

3. Father's Information

Name _____

Birthdate _____/_____/_____ ❑Stepfather ❑ Guardian

Employer_____

Work # (_____)_____

Home # (_____)_____

Cell # (_____)_____

SS #_____

E-mail Address_____

Active duty military at this time? ❑Yes ❑No

4. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ❑ Yes ❑ No

5. Person Responsible for Account

Name_____

Billing Address _____

_____

City State Zip

If billing address is a P.O. Box, you MUST provide a physical address!

Physical Address:_____

_____

City State Zip

6. Primary Dental Insurance

Insurance Co. Name_____

Insurance Co. Phone # (_____)_____

Policy #_____ Group #_____

Policy Owner's Name_____

Relationship to patient_____

Policy Owner's Birth date _____/_____/_____

Social Security # _____

Policy's Owner's Employer _____

7. Secondary Dental Insurance (if applicable)

Insurance Co. Name_____

Insurance Co. Phone # (_____)_____

Policy #_____ Group #_____

Policy Owner's Name_____

Relationship to patient_____

Policy Owner's Birth date _____/_____/_____

Social Security # _____

Policy's Owner's Employer _____

8. Health History

Child's Physician_____

Phone (_____)_____

Is the child under the care of a physician? ❑Yes ❑No

Ever been hospitalized / surgery? ❑ Yes ❑No

Does your child have any allergies? ❑Yes ❑No

If so, please list_____

_____

Is your child allergic to: ❑Latex ❑ Penicillin

❑Amoxicillin ❑Tetracycline ❑ Local Anesthesia

❑Aspirin ❑Other(s): _____

_____

Please list all medications and dosage the child is currently taking:_____

_____

Does your child require pre medication before dental treatment? ____ Yes ____No

Has the child ever had any of the following problems?

Please check all that apply:

❑Tonsillitis	❑Respiratory Problems
❑Asthma	❑Blood Transfusion(s)
❑Leukemia/Anemia	❑Diabetes/Hypoglycemia
❑Hemophilia	❑Abnormal Bleeding
❑High/Low Blood Pressure	❑Hepatitis
❑Liver/Kidney Problems	❑Cancer/Tumors
❑HIV/AIDS/ARC	❑Tuberculosis TB
❑Psychiatric Problems	❑ ADHD/ADD
❑Fainting/Seizures	❑Cerebral Palsy
❑Heart Murmur	❑Rheumatic Fever
❑Congenital Heart Defect	❑Artificial Heart Valves
❑Scarlet Fever	❑Cleft lip/Palate
❑Autism	❑Developmental Delay

Please relate any other significant medical problems the child has: _____

_____

9. 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, legal guardian, or personal representative 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 Kingstowne 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. Kingstowne 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.

10. 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.

NAME:	CONTACT NUMBER:
_____	_____
_____	_____
_____	_____

11. I am aware that under state law (Virginia Code Section 32.1-45.1), health care providers are authorized to test patients for HIV antibodies or Hepatitis B and C whenever the health care provider, or any person employed by the health care provider, is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus or HIV or Hepatitis B or C virus. According to this law, I understand that I will be deemed to have consented to such testing, and to have a consented to the release of the test results to the health care provider or any person who may have been exposed. Positive test results will also be disclosed to me as medically necessary, as otherwise required for my treatment and as required or permitted by law. I understand that I will be given an opportunity for counseling in connection with such test results. In the event that any individual involved with my care is accidentally exposed to my blood or body fluids, I also consent to the drawing and testing of my blood for exposure to the above viruses. The results will remain confidential. However, I consent to the release of the test results to the exposed individual through his/her treating physician.

Guardian Signature_____Date_____

Kingstowne 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, Visa, & MasterCard

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

1. Metlife
2. Guardian
3. United Health Care
4. Principal
5. Delta Dental
6. United Concordia
7. Cigna
8. GEHA

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.

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.

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. An interest rate of 1.5% of the unpaid balance from the last date of service will be charged. 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:_____

24 Hour Cancellation Policy

Kingstowne 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. There will be a charge for broken appointments. Oral sedation appointments that are broken/missed without reasonable notice will result in a charge. This is due to the high volume of patients awaiting dental care at our facility.
I have read and understand the 24-hour cancellation policy:

Patient's Name: _____

Guardian's Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

KINGSTOWNE PEDIATRIC DENTISTRY
7025-D Manchester Blvd.
Alexandria, VA 22310
703-922-4000

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

Examples of how we use or disclose information for treatment purposes are:

- setting up an appointment for you
- examining your teeth, mouth, and oral health
- showing you treatment options

Examples of how we use or disclose your health information for payment purposes are:

- asking you about your dental or medical care plans, or other sources of payment
- preparing and sending bills or claims
- collecting unpaid amounts

Examples of how we use or disclose your health information for health care operations are:

- financial or billing audits
- business planning
- outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission.

Examples of how we use of disclose your health information without your permission are:

- when a state or federal law mandates that certain health information be reported for a specific purpose
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence
- disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

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.

Patient name _____

Signature _____ Date _____

I understand that when contacting me about my appointments, Kingstowne 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 name: _____

Relationship to patient: _____

Signature: _____ Date: _____