CARING *for* KIDS & PARENTS

MEDICAL HISTORY

Patient Name ______________________________ Birth Date ______________
Email ______________________________ Phone # ______________
Physician's Name ______________________________ Phone # ______________

Please answer all questions completely. If there is no applicable answer, please put NA

Are you allergic to latex? Y☐ N ☐
Are you taking any medications now? Y☐ N ☐ If yes, please list ______________________________

____

Are you pregnant? Y☐ N ☐ Have you ever had a sleep test? Y☐ N ☐ CPAP machine ever been recommended? Y☐ N ☐

Do you have, or have you had any of the following?

Are you allergic to or have you had a reaction to:

	Y	N		Y	N		Y	N		Y	N
AIDS	☐	☐	High Cholesterol	☐	☐	Prolonged Bleeding	☐	☐	Local Anesthetics	☐	☐
Seasonal Allergies	☐	☐	Hemophilia	☐	☐	Rheumatic Fever	☐	☐	Penicillin	☐	☐
Arthritis	☐	☐	Hepatitis A, B or C	☐	☐	Rheumatic Heart Disease	☐	☐	Other Antibiotics ________	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Sinus Condition	☐	☐	________________	☐	☐
Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Skin Disease	☐	☐	Sulfa Drugs	☐	☐
Cancer	☐	☐	Joint Replacement	☐	☐	Stroke	☐	☐	Barbiturates, Sedatives	☐	☐
Congenital Heart Defects	☐	☐	Kidney Disease	☐	☐	Thyroid Disease	☐	☐	or Sleeping Pills	☐	☐
Diabetes	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐	Aspirin	☐	☐
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Ulcer	☐	☐	Wine or Foods	☐	☐
Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease	☐	☐	Codeine	☐	☐
Frequent Headaches	☐	☐	Pace Maker	☐	☐	Psychological Disorder	☐	☐	Other Narcotics________	☐	☐
									________________		

Additional information about your health that we should know: ______________________________
Have you ever been hospitalized? Y☐ N ☐ If so, when: ______________________________
Were you ever advised by your doctor to have antibiotics before any medical or dental treatment? Y☐ N ☐
Have you ever had any serious trouble associated with any previous dental treatment? Y☐ N ☐
If so, please explain: ______________________________

DENTAL HISTORY

	Y	N
Bleeding Gums	☐	☐
Bad Breath	☐	☐
Sore areas in your mouth	☐	☐
Pain in or near your ears	☐	☐
Sensitivity to heat, cold or sweets	☐	☐
Frequent headaches or tired jaw	☐	☐
Have you ever been treated by a Periodontist? (gum specialist)	☐	☐
Have you ever been treated by and Orthodontist? (braces)	☐	☐
Do you have a specific Dental problem or pain?	☐	☐

	Y	N
Do you use recreational drugs?	☐	☐
If so, how often? ________________		
Do you consume alcohol?	☐	☐
If so, how often? ________________		
Do you smoke?	☐	☐
if so, how often? ________________		
Do you use smokeless tobacco?	☐	☐
Are you happy with your smile?	☐	☐
if no, why not ________________		

If yes, please explain: ______________________________
Were Panoramic x-rays (full mouth x-rays) taken within the last 3 years that you can obtain from your previous dentist? ☐ ☐

Patient or Guardian's Signature ______________________________ Date ______________

CARING FOR KIDS & PARENTS

901 Enterprise Pkwy, Suite 500 | Hampton, Virginia 23666 | Phone: (757) 896-4900

PATIENT INFORMATION

Patient Name: ____ Preferred Name: ___________________________________
(last) (first)

Birth Date: ___________________ SS#: ___________________ E-mail address: __________________________________

Marital Status (Please check one): Single __ Married __ Separated __ Divorced __ Widowed __ Sex: M ___ F ___

Address: ____ City: ______________________ State: ________ Zip: ____________

Home Phone: _______________________ Work Phone: _______________________ Cell Phone: _______________________

Whom may we thank for referring you? ____

PARENT/GUARDIAN OR SPOUSE INFORMATION

Name: ____ Relationship to patient: ________________________________
(last) (first)

Birth Date: ___________________ SS#: ___________________ E-mail address: __________________________________

Address: ____ City: ______________________ State: ________ Zip: ____________

Home Phone: _______________________ Work Phone: _______________________ Cell Phone: _______________________

PRIMARY INSURANCE

Name: ____

Relationship to patient: ____________________________

Address: ____

City: _________________ State: ________ Zip: __________

Birth Date: _________________ SS#: ________________

Employer: _______________________________________

Insurance Company: ______________________________

SECONDARY INSURANCE

Name: ____

Relationship to patient: ____________________________

Address: ____

City: _________________ State: ________ Zip: __________

Birth Date: _________________ SS#: ________________

Employer: _______________________________________

Insurance Company: ______________________________

ABOUT DENTAL INSURANCE

If you have dental insurance, payment is your responsibility, but we can help. Regardless, of what we might calculate as your dental benefits in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. Dental insurance is not a pay-all, but is a great supplement to allow you to obtain the highest quality of dentistry available. As a courtesy to you, we do accept assignment of benefit payments for most insurance companies. This will reduce your immediate out-of-pocket expenditures. Our estimates are based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make payment. After this time, all inquires, follow-ups, and payments due, become your responsibility.

I understand that I am responsible for ALL fees regardless of insurance coverage. Interest charges of 1.5% per month (18% per year) will be added to the entire unpaid balance after 60 days. I agree to pay all cost of collection, including, but not limited to, reasonable attorney's fees.

__________________________ Signature

_________________ Date

HIPAA Consent Form

From the office of: Caring for Kids & Parents

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, We Shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act Of 1996 (HIPAA).

The patient understands that

- Protected health information (PHI) may be disclosed or used for treatment payment or health care operations
- The practice has a Notice of Privacy Practices and that the patient can review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this consent

☐ Caring for Kids & Parents has permission to use any contact information written on patient registration form.

By checking this box, you give permission for the practice to leave, as thorough of a message as needed, from our dental office. This will include, but not limited to, appointment day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS is not considered 100% secure. (examples include cell phones, email and fax lines)

If you did not check the box above, below is a list of ways the office may contact you. Please check any that you <u>DO NOT</u> want the office to contact.

☐ Work Phone ☐ Work Email ☐ Work Fax ☐ Mail to Work ☐ Personal Cell
☐ Home Phone ☐ Home Email ☐ Home Fax ☐ Mail to Home ☐ Emergency Contact
☐ Any of the above

Please list the names of any people who can have access to your chart. Please state what part of your chart you want people with partial access to be able to receive (financial, treatment, health history, etc.).

____ Full Access/ Partial Access ____

____ Full Access/ Partial Access ____

____ Full Access/ Partial Access ____

Patient gives office permission to forward any verified contact information and PHI to patients ' specialists. Office may discuss pertinent patient information, including PHI, with labs, and product representatives Involved in patient's case through verified, unsecured. unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not entities, treat a different patient, or to refer the patient. See <u>45 CFR 164.506</u>. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients' case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient Name ____ Date _________________________
Print Parent/Legal Guardian Name ____ Date _________________________
Signature of Patient or Parent/Guardian ____ Date _________________________

☐ Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.