

# Pediatric Dental Care

10614 Warwick Avenue Suite B Fairfax, VA 22030 (703)-383-3434  
6120 Brandon Avenue Suite 114 Springfield, VA 22150 (703) 992-7100

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
Nickname: \_\_\_\_\_ Gender: \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Responsible Party Information

The following is for:  the patient's mother  the patient's father  the patient's guardian  
Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Has your child ever had any of the following?** (These questions help us to treat and better understand your child.) **Please check those that apply:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS / HIV+             | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Tonsillitis                     |
| <input type="checkbox"/> Allergies _____         | <input type="checkbox"/> Excessive Bleeding      | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Fainting                | (A.D.D. Dyslexia, Hyperactivity)               | <input type="checkbox"/> Tumors                          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> <b>Up to Date Immunizations</b> |
| <input type="checkbox"/> Autism                  | <input type="checkbox"/> Handicap / Disabilities | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Codeine Allergy                 |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Has Taken Phen / Fen    | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Latex Allergy                   |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Head Injuries           | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Penicillin Allergy              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hearing Impaired        | <input type="checkbox"/> Respiratory Problems  | OTHER:   |
| <input type="checkbox"/> Cleft Lip/Palate        | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> _____                           |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Seizure               | <input type="checkbox"/> _____                           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Sore Throat           |  |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Speech Problems       |  |
| <input type="checkbox"/> Ear Aches               | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stomach Problems      |  |
| <input type="checkbox"/> Emotional Problems      | <input type="checkbox"/> Jaundice                |  |  |

- Is your child's water fluoridated?  Yes  No
- Is your child taking any fluoride supplements?  Yes  No
- Has your child ever had any jaw pain or tenderness?  Yes  No
- Does your child brush their teeth daily?  Yes  No
- Does your child floss their teeth daily?  Yes  No

### Does your child have any of the following habits?

- Thumb / Finger sucking / Pacifier  Yes  No
- Nail biting  Yes  No
- Mouth breathing  Yes  No
- Nursing bottle habits / Breast-feeding  Yes  No

- Has your child ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Has your child been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Is your child now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Does your child have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child's health changes, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of parent or guardian

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  Dental Office  
 Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Employment Information

The following is for:  the patient's mother  the patient's father  the patient's guardian

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Our office may assist you in identifying your insurance benefits, but the ultimate decision is made by your insurance company on whether services are a covered benefit and how much to pay, if anything. It is your responsibility to verify insurance coverage and benefits with your insurance company prior to the time that services are rendered by our office. The office makes no representations regarding whether your insurance will cover any services we provide.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

A \$50 fee will be charged for each check returned by the bank.

I understand that the fee estimate listed for this dental care can only be extended for a period of Three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs of collections and reasonable attorney fees if suit be instituted hereunder.

The patient/parent/undersigned is responsible for costs and attorney fees (35%) if this account is sent to collection.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

This is the entire agreement of the parties and supercedes any prior written or oral representations or agreements concerning payment for services rendered.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Acct#:

### Cancellation policy:

I acknowledge that I will be responsible for **\$100 Broken or No Show Fee, if 24hr prior notice** is not given unless rescheduled by the office.

PRINT: \_\_\_\_\_ SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

### Financial Policy:

I hereby authorize Pediatric Dental Care to charge my credit card for any charges that incur from insurance discrepancies immediately following an insurance claim/explanation of benefits. The same credit card information will be used at co-payment or the following information listed below:

CREDIT CARD NUMBER: \_\_\_\_\_ VISA / MC

EXPIRATION DATE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME APPEARED ON CARD: \_\_\_\_\_

PRINT: \_\_\_\_\_ SIGN: \_\_\_\_\_

# Pediatric Dental Care

10614 Warwick Avenue Suite B, Fairfax, VA 22032

703-383-3434

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### Health Insurance Portability Accountability Act (HIPAA), 1996

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

#### SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_

#### SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. John Han DDS

10614 Warwick Avenue Suite B, Fairfax, VA 22030

703-383-3434

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

#### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.**

#### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Acknowledgement of Receipt Notice of Privacy Practices

**Purpose:** This form is used to obtain acknowledgement that you have been notified that our **NOTICE OF PRACTICE POLICIES** can be obtained via our office. This document is printable via the web-site for your records.

HIPAA web-site: <http://www.hhs.gov/ocr/hipaa/finalreg.html> (You May Refuse to Sign This Acknowledgement)

I, : \_\_\_\_\_, have received acknowledgement of this office's Notice of Privacy Practices.

Signature

Date