Hampton Roads Pediatric Dentistry and Orthodontics

Patient Information

Patient Name:_____Preferred Name: _____

Gender (M/F): _____ Birth Date: _____Age_____

Address: _____ _____

_____ Phone #: _____

Father's Name or Legal Guardian:_____ _____

Date of Birth: _____ Social Security #: _____

Address if different from child: _____ _____

Phone #:_____Marital Status: _____

Occupation: _____ Employer: _____

Work #: _____ Cell #:_____ Other #:_____ E-mail address: _____

Mother's Name or Legal Guardian: _____ _____

Date of Birth: _____ Social Security #: _____

Address if different from child: _____ _____

Phone #: _____Marital Status: _____

Occupation: _____ Employer: _____

Work #: _____ Cell #:_____ Other #: __ _____ E-mail address:_____

With whom does the patient live? _____

Whom may we thank for referring you to our office? _____

Insurance Information

PRIMARY INSURANCE

Subscriber's Name: _____ _____

Date of Birth: _____ Social Security #: _____

Insurance Plan Name: _____Address: _____

Insurance Plan Phone # _____ _____

Identification #: _____ Group#: _____

SECONDARY INSURANCE

Subscriber's Name: _____ _____

Date of Birth: _____ Social Security #: _____

Insurance Plan Name: _____Address: _____

Insurance Plan Phone # _____ _____

Identification #: _____ Group#: _____

I accept financial responsibility for all services rendered to my child. The parent or guardian bringing the patient to our office is responsible for payment of the account in full on the day treatment is rendered. I authorize the release of any medical information to process my insurance claims or payment assigned to H. Bobby Garofalis, D.D.S. and his associates. This office will assist in the prompt filing of all insurance forms; however, I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for any services not covered by my policy. In the event of default on my account, I agree to pay collection costs including attorney's fees and court costs which may represent one third of the balance due.

Signed _____ Date _____

PATIENT NAME_____

Medical Health History

Condition of child's general health: _____

Child's Physician: _____

Phone #: _____

Family Dentist:_____

Phone #: _____

Yes	No	
( )	( )	Does your child have regular medical exams?
( )	( )	Is your child up to date with immunizations:
( )	( )	Has your child been hospitalized? Date_____ Reason _____
( )	( )	Has your child ever had general anesthesia or sedation for medical reasons? Date _____Reason _____
( )	( )	Is your child presently taking medications? If so, what? _____
( )	( )	Has your child ever had blood transfusions:
( )	( )	Is your child presently undergoing any medical treatment? If so, what? _____
( )	( )	Is your child presently undergoing chemotherapy?
( )	( )	Does you child have an infectious or chronic disease? If so, what? _____
( )	( )	Does your child smoke or use tobacco products?
( )	( )	Is your child allergic to any Medicine? If so, what? _____
( )	( )	Is your child allergic to Latex?
( )	( )	Has your child experienced any unfavorable reactions from previous dental or medical care?
		If yes, please explain: _____

Has your child ever been diagnosed as having any conditions of the following:

Yes	No		Yes	No		Yes	No	
( )	( )	Blood-Circulatory	( )	( )	Gastrointestinal-Stomach	( )	( )	Muscles
( )	( )	Bones	( )	( )	Kidney-Bladder	( )	( )	Nervous System
( )	( )	Endocrine Glands	( )	( )	Heart	( )	( )	Prosthetic Valves & Joints
( )	( )	Eyes, Ears, Nose	( )	( )	Liver	( )	( )	Skin Throat
( )	( )	Respiratory	( )	( )	Tonsils/Adenoids			

If yes, please explain._____

Yes	No		Yes	No		Yes	No	
( )	( )	AIDS	( )	( )	Eye Problems _____	( )	( )	Pregnant
( )	( )	Anemia	( )	( )	Excessive Bleeding Problems	( )	( )	Psychiatric Disorder
( )	( )	Allergy	( )	( )	Fainting	( )	( )	Rheumatic Fever
( )	( )	Arthritis	( )	( )	Hearing Loss	( )	( )	Scarlet Fever
( )	( )	Asthma	( )	( )	Heart Disease/Hear Murmur	( )	( )	Scoliosis
( )	( )	Autism	( )	( )	Hemophilia	( )	( )	Sickle Cell Anemia
( )	( )	Brain Injury	( )	( )	Hepatitis- Type _____	( )	( )	Sinus Problems
( )	( )	Bronchitis	( )	( )	Hyperactivity	( )	( )	Frequent Sore Throats
( )	( )	Cancer	( )	( )	Jaundice	( )	( )	Speech Therapy
( )	( )	Cerebral Palsy	( )	( )	Kawasaki Disease	( )	( )	Spina Bifida
( )	( )	Chicken Pox	( )	( )	Leukemia	( )	( )	Syndrome _____
( )	( )	Cleft Lip/Palate	( )	( )	Measles	( )	( )	Tetanus
( )	( )	Convulsions/Seizures	( )	( )	Mumps	( )	( )	Tuberculosis
( )	( )	Diabetes	( )	( )	Mouth Breathing	( )	( )	Venereal Disease
( )	( )	Diphtheria	( )	( )	Nutritional Deficiency	( )	( )	Whooping Cough
( )	( )	Drug or Alcohol Abuse	( )	( )	Orthopedic Problems	( )	( )	Other _____
( )	( )	Epilepsy	( )	( )	Polio			

Dental Health History

Yes	No	
( )	( )	Does your child have a dental condition about which you are especially concerned? Explain_____
( )	( )	Is this your child's first visit to the dentist? If not, date of last dental care_____
( )	( )	Has your child ever received injuries to the head, jaw, mouth or teeth? Explain _____
( )	( )	Does your child have a toothache?
( )	( )	Was your child a thumb/finger sucker? Age discontinued _____
( )	( )	Did your child use a pacifier? Age discontinued _____
( )	( )	Was your child bottle fed? Age discontinued_____
( )	( )	Was your child breast-fed? Age discontinued_____
( )	( )	Is your child a mouth breather?
( )	( )	Does your child grind or clinch his/her teeth?
( )	( )	Does your child's gums bleed?
( )	( )	Is your child presently taking a fluoride supplement? If so, what? _____
		What is your water source? Public System _____ Private Well _____ Reverse Osmosis System _____
		How often are your child's teeth brushed per day? _____ By whom? _____ What type toothpaste? _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment. I certify that I have read and understand the above questions. I will not hold Dr. H. Bobby Garofalis or his staff responsible for any errors or omissions I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Parent of Legal Guardian Relationship to Patient Witness Signature Date

Patient's Name _____

APPOINTMENT POLICY

An appointment in our schedule is a bond of trust that we will be here to serve your child and they will be present for treatment. We strive to create a schedule that most efficiently provides for the dental needs of all of the patients we serve.

APPOINTMENT AGREEMENT

We at Hampton Roads Pediatric Dentistry ask that you agree to do your part in ensuring optimal dental health for your child. Please arrive on-time and ready for each and every scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. If you arrive more than 10 minutes late we will do our best to work you into the schedule if time allows or we may have to re-appoint to another day. Always call our office if you know you are running late. Our office policy is firm in this regard.

CANCELLATIONS

Additionally, while we understand that things may come up, it's very important that we receive notice of a change in plans at least **48-hours** in advance.

Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office.

If an appointment is missed or canceled within the 48 hour window we will call and a letter will be sent to your home reminding you of our policy and the effects of your missed appointment. We also reserve the right to charge you up to $25 for each half hour of appointment time scheduled. After two missed appointments we reserve the right to not preschedule appointments but rather put you on a quick call list for future appointments.

Please note after three missed appointments we reserve the right to no longer schedule appointments for your child and they may be dismissed from the practice.

CONFIRMATION POLICY

As a courtesy to our patients we will perform reminder emails/text prior to your appointment. We do ask that if we are unable to reach you directly that you call our practice to confirm that you will be on time for your scheduled appointment.

I have read the policy above. I understand and agree to abide by the listed terms.

_____

Signature of Financially Responsible Party Date

New Patient Financial Policies Document

Welcome to our office:

We would like to take this opportunity to thank you for choosing our Practice for your dental needs. We will work very hard to ensure you and your family receives the best care possible with every effort being made to address all your cares and concerns.

At this time we would like to let you know how our business office works:

- **As a courtesy, we will file your insurance claims; however, any balance not covered by the insurance is the patient's responsibility.**
- **All co-pays, deductibles and non-covered procedures are due on the day the services are rendered unless specific arrangements are made before leaving the office. We accept cash, check, credit cards (Visa, MasterCard, Discover, and CareCredit.) Ask us for more information about CareCredit. No personal checks accepted exceeding $50. _____***(initial)*
- **Any *estimate* given to you by the office staff for treatment is exactly that, "an estimate." The insurance companies do not guarantee any payment until they receive the claim, review it, and process it according to the specific plan allowables, deductibles and co-pays.**
- **We have retained an outside management company, Orthosynetics, Inc. to handle the follow up on all of our insurance claims and patient balances.**
- **Our office sends out current and monthly statements so you will be kept informed of your balance at all times. Should you have any questions when you receive your statement, please call OrthoSynetics Dental Financial Services at (800)779-0126 for clarification.**
- **A $50 processing fee will be assessed for returned checks. _____***(initial)*
- **Any account that still has a balance once it is 30 days old will receive a follow up call from an account manager at Orthosynetics.**
    - **Orthosynetics' account managers are able to process check and credit card payments over the phone to assist you in clearing up any balance you may have and can be reached at (800)779-0126.**
    - **Once attempts have been made by phone and there is no response to the courtesy calls, the account manager will send out a "15 days to pay" letter, then the account will be sent to a third party collections agency. You will be responsible for any additional fees.**

I have read and understand the policy stated above and I accept the financial responsibility as explained to me.

Patient Name: _____

Bill Party Name: (PLEASE PRINT) _____

Bill Party Signature: _____

Date: _____

Hampton Roads Pediatric Dentistry and Orthodontics

Consent for Dental Treatment

Patient's Name_____ Date of Birth_____

I request and authorize H. Bobby Garofalis, DDS and other health care professionals on his staff to perform or assist in the performance of the following but not necessarily limited to:

- Dental Examinations
- Prophylaxis (Cleaning), Necessary X-rays, Fluoride Treatments
- Fillings
- Sealants
- Extractions/Oral Surgery
- Space Maintenance/Interceptive Orthodontics
- Crowns
- Endodontics/Nerve Treatments
- Emergency Dental Treatment
- Other

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.

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.

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.

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 of local anesthetics may also be characterized by excitation, depression, nervousness, dizziness, blurred vision, tremors, drowsiness, convulsions (seizures), unconsciousness and possibly cardiac/respiratory arrest. 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.

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the 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 tones.

I understand that should the child become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such movements, it may be necessary to use physical restraints such as a papoose board. The parent or guardian will be informed of the need for physical restraint will be asked to assist placing their child in such restraint.

My signature below signifies I authorize the use of physical restraint, when deemed necessary to avoid possible injury to the child.

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

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. I acknowledge that the dentist has explained all of the above to me in a thorough and comprehensible manner, and that my questions about my treatment and its attendant risks have been answered to my satisfaction.

Signature _____ Relationship to Patient _____

Date _____ Time _____

Witness _____

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/Names of Patients _____

Please Print Legal Guardian 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)

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU, WHICH IS PROTECTED UNDER THE HIPAA PRIVACY RULE MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION.

THE EFFECTIVE DATE OF THIS NOTICE IS ___September 23, 2013_____
PLEASE REVIEW THE FORM CAREFULLY. THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of PENINSULA PEDIATRIC DENTISTRY & ORTHODONTICS, COLISEUM PEDIATRIC DENTISTRY & ORTHODONTICS, WILLIAMSBURG PEDIATRIC DENTISTRY & ORTHODONTICS, ADVANCED SEDATION DENTISTRY

To protect the privacy of your medical information. We provide benefits to you as described in your benefits literature. As a result of offering benefits, we are required to follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice at any time. If we make changes to this notice, we will revise it and send a new notice to all covered persons at that time. We reserve the right to make any changes apply to all your protected health information maintained before and after the effective date of the new notice.

Purposes for which We May Use or Disclose Your Protected Health Information Without Your Consent or Authorization

We may use and disclose your protected health information for the following purposes:

- *Treatment*. For example, we may disclose your protected health information to determine if a medical condition is pre-existing or for the pre-certification of care.
- *Payment*. For example, we may use or disclose your protected health information to business associates or insurance carriers for the payment of claims or to provide eligibility information to your doctor when you receive treatment.
- *Health Care Operations*. For example, we may use or disclose your medical information (i) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (ii) to authorize business associates to perform data aggregation services (iii) to perform normal employee benefits operations.
- *As Required By Law*. For example, we must allow the U.S. Department of Health and Human Services to audit Plan records. We may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.
- *To Business Associates*. We may disclose your medical information to business associates we hire to assist us. Each business associate must agree in writing to ensure the continuing confidentiality and security of your medical information.
- *Sale of Business*. In the event that the company is sold or merged with another organization, your protected health information will become the property of the new owner.

We may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give us your agreement.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosure Requiring Your Authorization

Certain uses and disclosures require your specific authorization to include if applicable, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and any sale of PHI. Sale of PHI refers to any direct or indirect remuneration tied to disclosure of PHI with certain exceptions such as for public health purposes, purposes for treatment or payment, research with reasonable cost-based fee, disclosure to business associate to perform services, if only remuneration is for the services, individual requested disclosures, or disclosures required by law.

Uses and Disclosures with Your Permission

We will not use or disclose your medical information for any other purposes unless you give your written authorization to do so. Genetic information is not permitted to be used or disclosed for underwriting purposes (if applicable). Genetic information includes genetic tests and manifested diseases or disorders of you and your family members. If you give written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information we maintain, unless we have taken action in reliance on your authorization.

Your Rights

You may make a written request to do one or more of the following concerning your protected health information that we maintain:

- To put additional restrictions on the use and disclosure of your medical information. We do not have to agree to your request.
- To obtain an electronic copy of PHI. The electronic copy may be provided in the form and format requested by you or if not readily available, then you may receive electronic PHI in a mutually agreeable machine readable format such as MS Word, Excel, PDF or HTML. In limited cases, we do not have to agree to your request.
- To be notified of a breach of unsecured PHI.
- To communicate with you in confidence about your medical information by a different means or at a different location than we are currently doing. We do not have to agree to your request unless such confidential communications are necessary to avoid endangering you. Your request must specify the alternative means or location to communicate with you in confidence.
- To see and get copies of your protected health information. In limited cases, we do not have to agree to your request.
- To correct your medical information. In some cases, we do not have to agree to your request.
- To receive a list of disclosures of your protected health information that we and our business associates made for certain purposes for the last 6 years (but not for disclosures before the date your coverage began).
- To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). We will give you the necessary information and forms for you to complete and return to the Contact Office.

Complaints

If you believe your privacy rights have been violated, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us as indicated below:

Contact Officer: Aleksandra Soldo- Hampton Roads Pediatric Dentistry and Orthodontics

Address: 220 Nat Turner Boulevard, Newport News, VA 23606
Telephone: (757) 240-5711 Fax: (757)-240-4939
Email: ppd@hrpediatricdentistry.com

Address: 2113 Hartford Road, Ste. C, Hampton, VA 23666
Telephone: (757) 838-0800 Fax: (757) 827-8532
Email: cpd@hrpediatricdentistry.com

Address: 5388 Discovery Park Boulevard, Ste. 240, Williamsburg, VA 23188
Telephone: (757) 259-9703 Fax: (757) 259-9715
Email: wpd5388@hrpediatricdentistry.com

Address: 2111 Hartford Road, Ste. C, Hampton, VA 23666
Telephone: (757) 327-7843 Fax: (757) 827-8532
Email: surgerycenter@hrpediatricdentistry.com

Address: 6882 Main Street, Ste. A, Gloucester, VA 23061
Telephone: (804)695-2575 Fax (804) 695-2815
Email: Courthouse@hrpediatricdentistry.com

Address: 446 Effingham Street, Portsmouth, VA 23704
Telephone: (757)397-9801 Fax: (757)397-9805
Email: FriendlyFaces@hrpediatricdentistry.com

Address: 237 Hanbury Road E, Ste. 30, Chesapeake, VA 23322
Telephone: (757) 547-2134 Fax: (757)410-4765
Email: hpd@hrpediatricdentistry.com

Address: 4291 Holland Road, Ste. 211, Virginia Beach, VA 23452
Telephone: (757) 495-7866 Fax: (757)445-1844
Email: hpd@hrpediatricdentistry.com