Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____ (LAST / FIRST / MI)

Nickname: _____ ☐ Male ☐ Female

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

School: _____ Grade: _____

Child's Home #: (____)_____ SS #: _____

E-mail Address: _____

Child's Home Address:

_____ APT/CONDO #

_____ CITY / STATE / ZIP

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: __/__/__

Hm #: (____)_____ Cell #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

☐ Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: __/__/__

Hm #: (____)_____ Cell #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____ CITY / STATE / ZIP

Hm #: (____)_____ DL #: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ Ext: ____ Hm #: (____)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/__ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/__ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

6 Why did you bring the child to the dentist today? _____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:
☐ Good ☐ Fair ☐ Poor

Has your child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

Please list all drugs that the child is currently taking: _____

_____

_____

Please list all drugs/materials that the child is allergic to: _____

_____

_____

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

7 Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	ADD/ADHD	Y	N	Handicaps / Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Artificial Bones / Joints / Valves	Y	N	Hepatitis
			Y	N	HIV+ / AIDS
Y	N	Asthma	Y	N	Kidney / Liver Problems
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Sickle Cell Disease / Traits
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any serious medical problems that the child has had:

_____

_____

_____

8 Does/did the child have any of the following habits?

Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb / Finger Sucking

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Neighbor or Relative not living with you.

Name: _____ Phone: (____)_____

Address: _____

_____
CITY STATE ZIP

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I understand that the information that 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 authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

Current Medication Record

Name: _____ *Date of Birth:* _____

Date:	Medication:	Stop Date:

Ashland Dental Arts

Welcome!

All of us at Ashland Dental Arts are committed to providing you and your family with quality dental care with reasonable fees. We feel a clear understanding of your responsibilities is essential to the well being of our relationship. If you should have any questions, please feel free to ask.

Financial Policy:

Payment, in full, is due at the time of service. For your convenience, we accept cash, personal checks, debit cards, Amex, Discover, Mastercard, Visa and CareCredit.

Patients with Dental Insurance:

Patients are expected to provide current dental insurance information before any appointments. If insurance information is unable to be verified, patient will be expected to pay in full at the time of service. We will contact your benefits provider to verify dental coverage and request a breakdown of your dental benefits.

We will do our best to explain your coverage to you. Your co-insurance (co-pay) is due at the time of service. We will file claims and accept payments from your benefit provider on your behalf. Claims that are denied twice will become your responsibility. It is also the patient's responsibility to keep up with the insurance benefits remaining; we will help you with this to the best of our ability.

Returned checks are subject to a $40 returned check fee.

Please read the following carefully and sign where indicated:

If my account is turned over to an attorney for collections, I understand that I will be responsible for any additional fees added to my account, including, but not limited to, billing and service charges, legal fees and court costs.

I have read and understand the above mentioned policies.

Signature Print Name Date

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires and bad weather do occur. We ask our patients to give us 48 hours notice, whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with ***48 hours or more*** notice – ***no charge***

Cancellation or rescheduling of an appointment ***less than 48 hours in advanced*** may or may not be considered a broken appointment; it will be at our discretion.

If a patient no shows for an appointment- an automatic broken appointment fee will apply.

Failure to give 24 hour advance notice:

- We allow for one (1) broken appointment within a 12 month period
- Any additional broken appointments within a 12 month period will be charged a fee
    - $50 for a hygiene appointment (cleaning and check-up)
    - $75 for a doctor's appointment scheduled for an hour or less, each additional hour incurs an additional fee of $50

Definition of "Broken Appointment": A broken appointment is when you

- Cancel or reschedule an appointment with ***less than 48 hours notice***
- Do not show up for the scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services. As economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at Ashland Dental Arts.

I have read and understand the above mentioned policy.

Signature Print Name Date

Ashland Dental Arts
HIPAA Consent and Release Form

Name: _____ Date of Birth: _____

Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. It contains a section on Patient Rights outlining your rights under the law. You have a right to view our Notice before signing this consent. The terms of our Notice may change. If so, you may obtain a copy by contacting our office.

You have a right to request that we restrict how your protected health information is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to such restriction but if we agree, we will honor that agreement.

By signing this form, you agree to our use and disclosure of your protected health information for treatment, payment and healthcare operations. You have a right to revoke this consent, in writing signed by you. Such a revocation will not affect any disclosures already made in reliance upon your prior consent. This form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient (or responsible party) understands that:

- Protected health information may be disclosed for purposes of treatment, payment and healthcare operations, or for other purposes permitted or required by law.
- The office has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- The office reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the office does not have to agree to the restrictions.
- The patient has the right to revoke this consent in writing and all future disclosures will then cease.

_____

Signature (Patient or Responsible Party) *Date* [ ]self [ ]resp. party

Do you give permission to discuss your medical information with anyone else? [ ] YES [ ] NO If yes:

Name:	Relationship:	Telephone:

May we leave personal medical information on your voicemail/answering machine? [ ] YES [ ] NO
If yes, please provide the number we may use to leave the information: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Release of Dental Records to Ashland Dental Arts

Gretchen S. Drees, D.D.S.
Ashland Dental Arts
100 Arbor Oak Drive
Suite 101
Ashland, VA 23005
(804) 798-7388
Fax: (804) 798-0859
info@ashlanddentalarts.net

TO:

_____

Doctor

_____

_____

Address

_____

Phone Number

I, _____, authorize the release of my dental records and x-rays to Ashland Dental Arts.

_____

Signature *Date*

Date of Birth or Social Security #: _____

Address: _____

Phone Number: _____