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: _____

Please Note – if you require a pre-medication for your dental appointment, we require written documentation from your doctor stating your medication protocol before your appointment

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

While we will do our best to explain your dental coverage to you, it is ultimately your responsibility to know your dental benefits. It is also your responsibility to keep up with your remaining dental insurance benefits; we will help you with this to the best of our ability. **Your co-insurance (co-pay) and/or deductible is due at the time of service.** We will file claims and accept payments from your benefit provider on your behalf. If your claim is denied, we will file one (1) appeal on your behalf. If the appeal is denied, it is your responsibility to pay the full balance and contact your dental insurance company to provide the reason for denial.

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

If overpayment of services occurs, Dr. Drees will issue a refund check within fourteen (14) business days of the request being approved. If your original payment method was via credit/debit card, card processing fees will be deducted from the refunded amount. All refund checks require in-person pick-up.

Please read the following carefully and sign where indicated:

If my account is turned over to an attorney for collections, I understand that I am responsible for any additional fees added to my account, including, but not limited to, billing and service charges, collection fees, 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 a minimum 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 ***less than 48 hours in advance*** may or may not be considered a broken appointment; it will be at Dr. Drees' discretion.

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

Ashland Dental Arts does not accept appointment cancellations via text or email - patients must contact the office via phone.

Broken appointment fees are not payable by insurance companies and all fees must be paid prior to scheduling another appointment.

Failure to give 48 hours 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 the following fees:
    - $50 for a hygiene appointment (cleaning and check-up)
    - $75 per hour for a restorative appointment (treatment)

Please be aware that if you are more than 15 minutes late to your appointment, it will be considered a broken appointment and your appointment will need to be rescheduled.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. The appointment you schedule 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. I consent to the terms listed above.

Signature Print Name Date

Ashland Dental Arts

HIPAA Consent and Release Form

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 front desk. The terms of our 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 about you for treatment, payment, and healthcare 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, filing of insurance claims or health care operations.
- Protected health information (PHI) may be disclosed to third parties and affiliates that perform services for Ashland Dental Arts. These parties are required by law to sign a Business Associate Agreement (BAA) agreeing to protect the confidentiality of your PHI.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to 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.

[ ] YES [ ] NO **Do you give permission for Ashland Dental Arts to leave, as thorough of a message as needed, on your voicemail/answering machine. This includes, but is not limited to, appointment(s), treatment scheduled, documents to be signed, financial and collection concerns, and pre- or post-treatment directions.**

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

Name:	Telephone:	Full or Partial Access?*
		[ ] Full [ ] Partial
		[ ] Full [ ] Partial
		[ ] Full [ ] Partial

**If selecting partial access, list which parts of your chart: ex. financial, treatment, health history, etc.*

Pharmacy Name and Number: _____

_____

Patient's Name (Printed) *Date of Birth*

_____

Signature (Patient or Legal 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.

Office Staff Signature: _____ Printed Name: _____ Date: _____

Witnessed Staff Signature: _____ Printed Name: _____ Date: _____

Effective 1/1/2023

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: _____