



18474 Crossroad Pkwy, Culpeper, VA 22701 | 540-727-8200 | www.culpeperkidsdentistry.com

## Patient Information

Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Male:  Female:   
Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Who has legal custody of child? \_\_\_\_\_ Special Interests: \_\_\_\_\_

## Parent Or Legal Guardian's Contact Information

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Employer: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status  Single  Married  Separated  Widowed  Divorced

## Dental Insurance Information of Responsible Party

Is your child covered under Virginia Medicaid?  YES  NO If YES, Patient's ID #: \_\_\_\_\_

Primary Dental Insurance: \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_  
Card Holder: \_\_\_\_\_  
DOB: \_\_\_\_\_ Ins Phone # \_\_\_\_\_  
Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Dental Insurance: \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_  
Card Holder: \_\_\_\_\_  
DOB: \_\_\_\_\_ Ins Phone # \_\_\_\_\_  
Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Please list any person other than you who have your permission to bring the patient to his or her appointment and make decisions regarding your child's dental treatment.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_

### How did you hear about us?

- Mailer
- Insurance Company
- Website
- Google
- Friend: Name: \_\_\_\_\_
- Other: \_\_\_\_\_
- Community Event
- Facebook
- Yelp
- Sign

### Text Message Reminders and Confirmations:

- YES, I would like to receive text message reminders.
  - NO, I do not want to receive text message reminders.
- \*Data and messaging rates may apply\**

### Media and Facebook Consent:

- YES, my child may be photographed
  - NO, my child may not be photographed
- May we post these photos on Facebook?  YES  NO

*I certify that the information I have given is correct and true 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 history or information listed above. I authorize Culpeper Kids Dentistry to release any information including the diagnosis and the records of the treatment or examination rendered to my child during such dental care to third party payers and/or health practitioners. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, and restorative work including composite restorations, stainless steel crowns, pulpotomies, and space maintainers which are deemed advisable by the doctor. I authorize the use of my signature on all insurance submissions. In order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone, email or text message using any contact information that you provide. I am the parent, guardian, or personal representation of the child listed above and there are no court orders in effect that prohibit me from signing this consent.*

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA Notice of Privacy Practices Acknowledgment

Culpeper Kids Dentistry will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time and we will post the current notice at our facility and have copies available for the distribution. I acknowledge I have received, read and understand the **HIPAA NOTICE OF PRIVACY PRACTICES**.

I give Culpeper Kids Dentistry permission to speak to the following people (if any) regarding my child's health information:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Financial and Insurance Policies

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services affordable, we are pleased to offer you these options for payment;

- Visa, MasterCard, Discover and American Express
- Cash or check
- Care Credit (Third Party Financing)

We are happy to file dental insurance claims on your behalf if we are in your network. Insurance benefits are not determined by our office, but is an arrangement between you and your insurance company. Please be familiar with your coverage as each policy is different. Once we have been provided with the details of your coverage, including deductibles, we will be able to provide you with an **ESTIMATE** of your financial portion of your child's dental care. All copays and non-covered fees are due at time of service. **We are not responsible for how your insurance company handles claims and we cannot guarantee what your insurance company will pay on the claim. Whatever your insurance does not pay, you are responsible for the remaining balance.**

Please understand that filing your claim is a courtesy our office provides and does not guarantee payment to us. **Consequently, you are ultimately responsible financially for the services rendered.**

If you do not have dental insurance, all fees are due at time of service.

### Divorce and Separation:

The parent or guardian who brings the child for his/her visit is responsible for payment. This stands regardless of what a divorce decree may state. If your agreement or decree requires the other parent to pay for all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent prior to the appointment. If payment is not made in full before appointment, we reserve the right to reschedule the appointment.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# Pediatric Medical and Dental History

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

- Does your child have a primary care physician? If YES, please write name, practice name, & phone number.    Y    N    If YES: \_\_\_\_\_
- Is your child currently under a physician's care for any medical, emotional or behavioral conditions?    Y    N    If YES: \_\_\_\_\_
- Was your child born prematurely?    Y    N    If YES: \_\_\_\_\_
- Did your child spend time in the neonatal ICU after birth?    Y    N    If YES: \_\_\_\_\_
- Has your child ever had surgery?    Y    N    If YES: \_\_\_\_\_
- Has your child ever been hospitalized for any medical conditions or because of significant injury?    Y    N    If YES: \_\_\_\_\_
- Does your child take any prescription or OTC medicines? Please list.    Y    N    If YES: \_\_\_\_\_
- Does your child have any allergies to medications, latex, food, or metals?    Y    N    If YES: \_\_\_\_\_
- Are your child's immunizations up to date?    Y    N    If NO: \_\_\_\_\_

### Does your child have any of the following? Please circle all that apply:

ADHD	Developmental Disabilities	HIV/AIDS	Spina Bifida
Anemia	Diabetes	Hydrocephalus	Sleep Disorder/Snoring
Artificial Joints	Eating Disorder	Hypertension	Stroke/Aneurysm
Artificial Heart Valve	Emotional Disorder	Intellectual Disability	Syndrome: _____
Asthma/Lung Disease	Epilepsy or Seizures	Kidney Disease	Thyroid Conditions
Autism- Minor / Severe	Gastrointestinal or Digestive Problems	Liver Disease	TMJ Dysfunction
Bleeding Disorder/Hemophilia	Heart Murmur	Reflux	Tonsillitis
Cancer	Hearing/Speech Problems	Rheumatic Heart Fever	Tuberculosis
Cerebral Palsy	Heart Disease/Defect	Rheumatism	Tumors or Growth
Cleft Lip & Palate	Hepatitis	Radiation Treatment	Urinary Tract Infection
Chemotherapy		Sickle Cell Disease/Trait	Visual Impairment

- Do any of the conditions above need further explanation?    Y    N    If YES: \_\_\_\_\_
- Has your child ever had any illnesses or conditions not listed?    Y    N    If YES: \_\_\_\_\_

## Dental History

- Is today your child's first dental visit?    Y    N    If NO, how long since last visit: \_\_\_\_\_
- Has your child had dental x-rays in the past?    Y    N
- Which dental practice did your child go to? \_\_\_\_\_
- What brings you to the dental office today? \_\_\_\_\_
- How do you think your child will behave with the dentist? \_\_\_\_\_
- Any unhappy dental experiences?    Y    N    If YES: \_\_\_\_\_
- Has your child complained about dental problems?    Y    N    If YES: \_\_\_\_\_
- Has your child injured their teeth, mouth, or head?    Y    N    If YES: \_\_\_\_\_
- Is your water supply fluoridated?    Y    N    How often does your child brush/floss? \_\_\_\_\_
- Does your child take fluoride supplements?    Y    N
- Does your child play sports?    Y    N    If YES, do they currently wear a mouth guard? \_\_\_\_\_

### Does your child have or do any of the following?

Thumb/Finger Sucking	Y    N	Pacifier	Y    N	Grinding/Clenching	Y    N
Lip Biting/Tongue Thrusting	Y    N	Breast Feeding	Y    N	Nursing/Bottle Habits	Y    N
Nail Biting	Y    N	Sippy Cup with Sugary Liquids	Y    N	Sugary Drinks	Y    N
Sugary Snacks/Chips/Crackers	Y    N				

**Additional Comments:**



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## Scheduling Policy

We take the time that we have scheduled for your child very seriously and we hope for the same consideration. As a courtesy, we attempt to remind our patients of their appointment by either phone call, email or text message and ask for a confirmation response. However, we hope that our patients do not rely solely on our courtesy reminders. We reserve the right to charge for appointments broken without the proper 24 hours or 1 business days' notice. I furthermore have read a more detail copy of our **APPOINTMENT POLICY** below and understand the policies set forth.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Appointment Policy

*Culpeper Kids Dentistry is pediatric dental practice, which means our focus is strictly towards children and individuals with special needs. As you know, children are unpredictable and require one on one attention. With that in mind, please know that we strive to see all patients on time for their scheduled appointments. There are times when our schedule is delayed in order to accommodate a child with an emergency. We would give this same special attention to your child if needed, so please accept our apology in advance should this occur during your appointment time.*

- **A patient's biological parent or legal guardian must accompany him or her for the initial appointment and must fill out the new patient registration. Parents/Legal Guardian must remain in the office during child's appointment.**
- If a parent or legal guardian is unable to come to future appointments, a consent form must be signed to inform us who has permission to accompany the child and authorize treatment.
- Each scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. **If a cancellation is unavoidable, please call our office at least 48 hours in advance so that we may give the time to another patient.**
- **Please plan to arrive 10 minutes or more before your scheduled appointment.** This will allow you time to complete any additional paperwork so we may seat your child on time.
- **If you arrive 10 minutes late to your appointment, you may be asked to reschedule for the next available appointment time.**
- **Culpeper Kids Dentistry requires a confirmation** via text or phone call AT LEAST 2 days prior to your child's reserved appointment time. Otherwise, we reserve the right to cancel any unconfirmed appointments to accommodate other patients who may need that slot. You may reschedule this appointment to our next available time.
- Broken or missed appointments affect many people. **If two (2) missed appointments occur, OR two (2) cancellations occur without 48-hour notice, Culpeper Kids Dentistry reserves the right to refuse any future appointments.**

Culpeper Kids Dentistry reserves the right to dismiss a patient from the practice indefinitely if above policies are not followed through by parent or legal guardian. Otherwise, we will be happy to assist you in transferring the patient's records to another doctor. If at any time you have questions, please feel free to ask our staff or call our office. We appreciate you entrusting your child's dental health to us. Thank you for understanding our appointment policy!

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_