Welcome

Kidz Dentistry

6101 Redwood Square Center
Suite 300
Centreville, VA 20121

5047 Backlick Road
Suite A & B
Annandale, VA 22003

Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate _____/_____/_____ Child's Age _____

School_____Grade_____

Child's Home # (_____)_____

SS#_____

Child's Home Address:_____

_____
City State Zip

Email Address:_____

2. Who may we thank for referring you to our office?

_____

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship_____

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

6. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

7. 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 _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

8. 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 _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain_____

_____

_____

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

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

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

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or 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

10 Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____)_____

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

Please describe the child's current physical health...

Good **Fair** **Poor**

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

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I understand that the information 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 of Parent or Guardian Date Relationship to Patient

For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

Kidz Dentistry

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

Any alternatives to the recommended treatment, including no treatment, have been explained to me. I shall authorize for the doctor to treat and his/her staff to assist for the care of my child:

Examination, prophylaxis (cleaning), fluoride, x-rays if indicated.
Other treatment plan, if needed, is given separately and explained to me prior to treatment.

There are risks associated with any dental treatment. This includes the administration of any local or analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of the risks/complications are, but not limited to, the following:

*Infection
*Injuries to adjacent teeth and/or hard of soft tissues
*Bleeding
*Failure of wound to heal
*Dry socket
*Loss of teeth
*Instrument breakage
*Allergic reaction to drugs
*Bacterial endocarditis
*Breakage of roots
*Retained root fragments
*Swallowing and/or aspiration objects
*Failure of treatment to accomplish its purpose
*Trismus (jaw pain or difficulty opening mouth)
*Fracture of mandible (lower jaw) or maxilla (upper jaw)
*Opening between mouth and sinus mouth and nose
*Tooth or fragment in maxillary sinus
*Death (in very rare instances)

Additional oral surgery, hospitalizations and/or further treatment may be required in the event of any complications.

ACKNOWLEDGMENT

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

Date: _____ Child's name: _____

Signature of legal guardian: _____

Kidz Dentistry

PRACTICE POLICY

Welcome to our practice!! We are honored that you have chosen us to care for your child's dental needs. We have a team of exceptional pediatric dentists, orthodontist and staff. Our doctors are highly trained in the latest techniques of children's dentistry including preventative, restorative, orthodontic, endodontic, cosmetic and sedation dentistry. Our entire clinical staff are x-ray certified. Our administrative staff are dedicated to help you with your insurance and scheduling needs. All of our employees are well trained professionals who follow all OSHA requirements. Our mission is to give you the highest quality treatment in a warm and caring environment. Our office participates with many of the preferred provider plans.

The changes that are occurring in the health care industry have placed great demands on our office resources. We have established some policies and protocols to help our office run smoothly and thus provide better service to you. Please review these policies and make us aware of any special needs or concerns you may have.

APPOINTMENTS:

All patients are seen by appointment only. Emergencies will be worked into our schedule as best as possible. We ask that you call in advance so that we may reserve time for you.

It is ultimately the parent's/guardian's responsibility to be aware of an office appointment or if pre-medication is needed ahead of time. We understand that occasionally circumstances prevent you from keeping an appointment. When this happens, we ask that you call us as soon as possible (at least 48 business hours in advance). **It is the policy of the practice to charge the patient a minimum of $50 for a routine/cleaning appointment and minimum of $100 for a restorative appointment that is missed or broken without 48 business-hours notice.**

We also reserve the right to dismiss a patient from the practice who fails to appear more than two times for a scheduled appointment.

FINANCIAL RESPONSIBILITY:

We deal with many insurance plans, all with different requirements. The intricacies of all the different plans and policies make *it impossible for our staff to know all the specific details of every policy.* While we make every effort to assist you in receiving the best care and the maximum benefits to which you are entitled, **it is ultimately the parent's/guardian's responsibility as an insurance plan member to be aware of all the rules and requirements pertinent to your own plan.** Please familiarize yourself with your own dental policy.

We will file the patient's primary insurance claims; you are responsible for secondary insurance claim filing where applicable. Ultimately, you are directly responsible for

payment in full of any fees. If your insurance company has not paid your claim within 90 days the account balance will be reverted to the responsible party.

We are required to collect and you are responsible to pay the patient's designated co-insurance, co-payment, and/or deductible at the time of service.

All accounts 60 days will be considered past due. Past due accounts are subject to a monthly finance charge of 1.5%.

Past due accounts may be referred to an authorized collection agency for collection. A miminum fee of $50 will be assessed to all accounts that are forwarded to such an agency. Reasonable attorney fees incurred in attempts to collect on your account will also be assessed in applicable.

Accounts that have been referred to an outside agency will be placed on a CASH ONLY basis for any future treatment.

Personal checks that are returned due to "insufficient funds" or any other reason are subject to a $50 service fee.

After we submit the claim, your insurance company will advise us if there are any charges that are not covered, or any changes in their fee schedules. We issue monthly statement to our patients, and we require payment to be made upon receipt of the statement.

In keeping up with today's technologies, we routinely do natural white fillings. If white fillings are to be done, please ask for the insurance estimate information regarding composite (tooth colored) fillings. Many insurance companies do not pay or they downgrade these fillings due to exclusions to individual policy. The responsible party is liable for all additional cost for these fillings.

We love our children and hope that you enjoy your visits with us here!

Thank you for being a part of our practice!

Tricia T. Tran, D.D.S.
Founder of Kidz Dentistry and Springdale Kidz Dentistry, PLLC
Diplomate, American Board of Pediatric Dentistry

I,_____, acknowledge and understand the office policies.
Parent's Signature

_____
Date

Updated 5/24/2016

Kidz Dentistry 6101 Redwood Square Center. Suite 300. Centreville, Virginia 22101 PH: 703-222-0111

UPDATED FINANCIAL POLICY 2016

We are dedicated to providing you with the best possible care and helping you receive maximum insurance benefits. However, you need to **understand your insurance coverage: not all services are covered by all plans and we do not know the specifics of all insurance plans.** While the filing of insurance claims to insurers that we participate with is a service that we extend to our patients, all fees **ARE** ultimately the patient's responsibility. We accept most major insurance carriers. We file secondary insurance with participating insurance carriers only. Newborns must be added to your insurance policy within the first 30 days of life. Otherwise, you may not be able to enroll your child until the next open season. You will be held responsible for all services provided to your child, with or without insurance benefits.

If we do not participate with your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance company. However, payment is expected at the time service is rendered.

Due to current federal and insurance regulations, all co-payments, co-insurance and deductibles are collected at the time service. We accept cash, checks, Master Card, and Visa. The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family's account, and there are not outstanding patient balances on the family's account.

If both parents have insurance coverage, the primary insurance carrier is determined by "The Birthday Rule." Whichever parent's birthday falls earlier in the year is the holder of the primary insurance; the other parent retains secondary coverage. The parent with primary custody is usually the parent with whom the child resides and the parent who usually brings the child to Kidz Dentistry for care. The custodial parent is responsible for payment.

WE ENCOURAGE YOU TO CONTACT OUR OFFICE PROMPTLY FOR FURTHER ASSISTANCE IN HANDLING YOUR ACCOUNT

Additional Fees:

- **$25.00** Pre authorization.
- **$25.00** Duplication of Records/X-rays.
- $10.00 Year End Reports.
- **$50.00** Cancelled or missed routine recare/cleaning appointments not within 48-business hours.
- **$100.00** Cancelled or missed restorative appointments not within 48-business hours.
- We call before all appointments as a courtesy to our patients, but it is ultimately the parents' responsibility to keep the appointments.

PATIENT FINANCIAL AGREEMENT

I hereby authorize Kidz Dentistry in Centreville, A, to submit for benefits on my behalf for all services rendered. I certify the information I have provided with regard to my insurance coverage is correct. Furthermore, I authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to KIDZ DENTISTRY on my behalf.

I understand and agree regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read the above Financial Policy and have provided the true and correct insurance information. I will notify Kidz Dentistry of any changes in my insurance coverage.

_____

Printed name of Parent or Legal Guardian

_____

Signature of Parent or Legal Guardian Date

Springdale Kidz Dentistry, PLLC 5047 Backlick Road, Suites A & B, Annandale, VA 22003 PH: 703-462-8855

UPDATED FINANCIAL POLICY 2017

We are dedicated to providing you with the best possible care and helping you receive maximum insurance benefits. However, you need to **understand your insurance coverage: not all services are covered by all plans and we do not know the specifics of all insurance plans.** While the filing of insurance claims to insurers that we participate with is a service that we extend to our patients, all fees **ARE** ultimately the patient's responsibility. We accept most major insurance carriers. We file secondary insurance with participating insurance carriers only. Newborns must be added to your insurance policy within the first 30 days of life. Otherwise, you may not be able to enroll your child until the next open season. You will be held responsible for all services provided to your child, with or without insurance benefits.

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- We call before all appointments as a courtesy to our patients, but it is ultimately the parents' responsibility to keep the appointments.

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I hereby authorize Springdale Kidz Dentistry, PLLC in Annandale, VA to submit for benefits on my behalf for all services rendered. I certify the information I have provided with regard to my insurance coverage is correct. Furthermore, I authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to or SPRINGDALE KIDZ DENTISTRY, PLLC on my behalf.

I understand and agree regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read the above Financial Policy and have provided the true and correct insurance information. I will notify Springdale Kidz Dentistry, PLLC of any changes in my insurance coverage.

_____

Printed name of Parent or Legal Guardian

_____

Signature of Parent or Legal Guardian Date

Kidz Dentistry **6101 Redwood Square Center. Suite 300. Centreville, Virginia 22101 PH: 703-222-0111**
Springdale Kidz Dentistry **5047 Backlick Road, Suites A & B, Annandale, Virginia 22003 PH: 703-462-8855**

HIPAA ACKNOWLEGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____
Printed name of Parent or Legal Guardian

_____/_____
Signature of Parent or Legal Guardian / Date