hampton roads pediatric dentistry

Dr. H Bobby Garofalis & Associates

Chesapeake • Gloucester • Hampton • Newport News • Portsmouth • Virginia Beach-Red Mill & Town Center • Williamsburg • Yorktown

757-224-3006

NEW PATIENT PACKET

A ***PARENT*** or ***LEGAL GUARDIAN*** OF THE CHILD MUST COMPLETE THIS FORM.

PATIENT INFORMATION

Name of Patient: _____ **Nickname:** _____ **DOB:** _____ **Gender:** ☐ M ☐ F

Primary Address of Patient: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary phone number for appointment confirmations: _(___)_____

Name of person filling out this New Patient Paperwork today: _*PRINT PLEASE*_____

Relation to Patient: ☐ **Biological** ☐ **Adopted** ☐ **Foster** ☐ **Nanny** ☐ **Other:** _____

PARENT INFORMATION

GUARDIAN (I)

Name:_____ **Gender:** ☐ M ☐ F

DOB:_____ **SS#:** _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Home: (___) ___ **Cell:** (___) ___

Email: _____

☐ *Check box if Address is same as patient's listed above.*

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

Employer: _____

Work: (___) ___

GUARDIAN (II)

Name:_____ **Gender:** ☐ M ☐ F

DOB:_____ **SS#:** _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Home: (___) ___ **Cell:** (___) ___

Email: _____

☐ *Check box if Address is same as patient's listed above.*

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

Employer: _____

Work: (___) ___

Who does the patient live with? : ☐ Guardian 1 & 2 ☐ Guardian 1 ☐ Guardian 2 ☐ Other: _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____

DOB:_____ **SS#:** _____

Employer: _____

Phone: (___) ___

Insurance Co.: _____

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

Phone: (___) ___

Group/Policy #: _____

I.D. #: _____

SECONDARY COVERAGE

Name of Insured: _____

DOB:_____ **SS#:** _____

Employer: _____

Phone: (___) ___

Insurance Co.: _____

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

Phone: (___) ___

Group or Policy #: _____

I.D. #: _____

REFERRAL INFORMATION

How did you hear about Hampton Roads Pediatric Dentistry?

☐ Doctor/Dentist: _____

☐ Patient: _____ ☐ Social Media: _____ ☐ Other: _____

I certify that the information I have given is correct to the best of my knowledge. The information will be held in confidence and it is my responsibility to inform HRPD of any changes in the patient's medical status. I authorize the release of all information necessary to secure benefits otherwise payable to me. I directly assign Dr. H. Bobby Garofalis and his associates all insurance payments otherwise payable to me. I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to, third party collection fees of 33 1/3%, as well as court filing fees and attorney fees. I affirm that my signature represents my agreement to all the terms mentioned above.

Parent/Guardian Signature: _____ **Date:** _____

Patient Name: _____ **DOB:** _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? : ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay

Has your child ever been to the dentist? : ☐ Yes ☐ No **Last Exam Date:** : _____

Has your child had dental X-Rays in the past six months? ☐ Yes ☐ No **Date of Last X-Rays:** _____

Has your child ever complained about a dental problem, or had an unhappy dental experience you would like to share with us?

☐ Yes ☐ No **Explain:** _____

Please list any dental concerns you would like to discuss today: _____

DENTAL HABITS

Does your child currently… (check all that apply)

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Bite/Chew Nails ☐ Tongue Thrust ☐ Bottle Feed
☐ Use Pacifier ☐ Tongue/Cheek Chew ☐ Clench/Grind Teeth ☐ Mouth Breather ☐ Breast Feed

HYGIENE ROUTINE

(check all that apply)

☐ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child:_____/day ☐ Snack between Meals --- Type of snacks:
☐ Fluoride Mouthwash ☐ Dental Floss:____/week ☐ Brushing by Parent:_____/day _____

MEDICAL HISTORY

Are immunizations current? : ☐ Yes ☐ No

Child's physician:_____**Phone: (____) ---**_____**Date Last Exam:** _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain)**:** _____

_____

Current Medications: _____

Has your child been diagnosed and/or treated for any of the following…☐ Yes ☐ No *(check all that apply)*

☐ Blood Disorder/Anemia
☐ Abnormal Bleeding/Hemophilia
☐ Immune Disorder/HIV/AIDS
☐ Cancer/Tumor/Leukemia
☐ Heart Murmur/Defect/Surgery
☐ Brain Injury
☐ Fainting
☐ Epilepsy/Seizures/Convulsions
☐ Orthopedic Problems
☐ Spina Bifida
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Liver Disease/Jaundice
☐ Hepatitis - Type
☐ Autism Spectrum
☐ Tuberculosis (TB)
☐ Mouth Breathing
☐ Asthma/Reactive Airway
☐ Bronchitis
☐ Tonsillitis
☐ Congenital Birth Defects
☐ Premature/Low Birth Weight
☐ Cleft Lip/Palate
☐ Mental/Cognitive/Social Delay
☐ Diabetes
☐ Sickle Cell Trait
☐ Stomach/GI Disorders
☐ Kidney Problems
☐ Rheumatic Fever
☐ ADD/ADHD
☐ Eating Disorder
☐ Speech Disorder
☐ Vision Problems
☐ Hearing Problems/Deaf
☐ Drug/Alcohol Abuse
☐ Pregnant

ALLERGIES:

☐ Drug: _____
☐ Food: _____
☐ Seasonal
☐ Hives
☐ Latex
☐ Other:

If there is any additional information that you think might be of value to us in treating your child, please feel free to notate it on this form. I certify that I have read and understand the above questions. The information will be held in confidence and it is my responsibility to inform HRPD of changes in the patient's medical status. I will not hold Dr. H. Bobby Garofalis & his associates, or his staff, responsible for any errors or omissions I may have made in the completion of this form.

Parent/Guardian Signature: _____ **Date:** _____

HRPD Front Desk Signature: _____ **Date:** _____

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FINANCIAL & APPOINTMENT POLICY

PATIENT'S NAME	DATE	PATIENT'S DATE OF BIRTH

FINANCIAL POLICY

Insurance: As a courtesy for our patients we are happy to file dental claims for our families who have dental insurance. Filing insurance is not a guarantee of payment. HRPD will make no more than 2 attempts to file and settle an insurance claim within 6 months from the date of service. Please be informed that our staff will ***never*** guarantee coverage/payment by your insurance provider, for services rendered, by our offices. Insurance companies do not guarantee payment until they receive the claim, review it, and process it according to the specific plan allowances, deductibles and co-pays. Our doctors recommend treatment based on the patient's needs, not what your insurance will pay. Therefore, we will do everything possible to maximize your benefits. It is your responsibility to know and understand your own dental insurance plan and allowances. If your insurance claim is not resolved or settled within 6 months from the date of service, then the account balance becomes your financial responsibility. You have the final responsibility for payment for any services rendered, not covered by insurance. Your insurance information, such as id cards, legal decrees, or court-orders must be presented to the office and documented with HRPD. It is your responsibility to update us with any insurance changes, as they arise. HRPD does NOT file claims to Medical Insurance Policies.

Payment Due: The full balance of treatment; co-pays, deductibles and non-covered procedures are due at the time services are rendered. Our offices accept cash, checks (under $50), Visa, MC, Discover, and CareCredit. There is a $50 fee for any checks returned by the bank.

Past Due Accounts & Statements: Our offices send out monthly statements for all accounts with a balance. Unless prior arrangements have been approved through our business office, balances on accounts are due and payable when the 1st statement is issued.

- 2nd Statement – We send a "Friendly Letter" reminding you of your balance and to contact our offices with any questions you might have or to make payment.
- 3rd Statement – We send another "Friendly Letter" again reminding you that your account has a balance and to please submit payment as soon as possible.
- Final Notice – After 3 statements have been sent regarding your account balance, this Final Notice states that you have 10 days to reconcile your account or you will be sent to collections.
- Collections – Your account will be referred to a third-party collections agency, where you will be financially responsible for all reasonable expenses incurred, including but not limited to, third party collection fees of 33 1/3%.
- No services will be rendered if there is a family balance.

_____ ***(Initial)***

APPOINTMENT POLICY

When we schedule an appointment for your child, that time is reserved solely for your child. We will be here to serve your child and in return we expect them to be present for all scheduled appointments. Our doctors and staff value your time and hope you value ours. We strive to create an appointment schedule that most efficiently provides time for the dental needs of all the patients we serve.

A parent or legal guardian **MUST** accompany any child under the age of 18 to all appointments and is **REQUIRED** to be present in the office at all times. In order to have someone else accompany the child to appointments, you **MUST** first have a **NOTORIZED** permission letter on file granting that individual permission to bring your child to the appointment. For your convenience, a public notary is available at each location, at no charge. ***A NOTARIZED PERMISSION LETTER IS NOT VALID FOR TREATMENT APPOINTMENTS WHERE THE PATIENT IS TO BE ADMINISTERED CONSCIOUS SEDATION MEDICATION OR GENERAL ANESTHESIA***

Arrival Time: Please plan to arrive 10-15 minutes before your scheduled appointment. This will allow time for parking and to complete any additional paperwork required. We strive to see all patients on time for their scheduled appointment. There are times when our schedule might become delayed. Please accept our apology in advance should this occur during your appointment.

Canceling or Rescheduling: If you are unable to keep a scheduled appointment, a 48-hour notice is required. We understand that unforeseen emergencies do occur, however, we reserve the right to charge your account a $25 fee for repeated last-minute cancellations or "No Show" broken appointments as follows:

- Preventative - If you have 2 "No Show" or "Cancelled" appointments with less than a 48-hour notice, our office reserves the right to dismiss the patient from our practice or charge a $25 broken appointment fee.
- Restorative - Due to the large amount of time reserved and set up required, restorative appointments missed or cancelled with less than a 24-hour notice, we reserve the right to dismiss the patient from our practice or charge a $40 broken appointment fee.
- Confirmations: As a courtesy to our patients, our staff will make personal appointment reminder calls, in addition to our automated text and emailing confirmation system. In the event that we are unable to reach you, please contact our office to confirm that you will be on time for your scheduled appointment. ***Always call the office if you are running late!****

_____***(Initial)***

I have read the above Financial and Appointment Policies. I understand my obligations with Hampton Roads Pediatric Dentistry. I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable cost and fees associated with the collection of the account balance, including but not limited to, third party collection fees of 33 1/3%, as well as court filing fees and attorney fees. I affirm that my signature represents my agreement to all the terms mentioned above.

Parent / Guardian Print Name: _____

Parent / Guardian Signature: _____ **Date:** _____

HRPD Front Desk Signature: _____ **Date:** _____

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CONSENTS & ACKNOWLEDGEMENTS

PATIENT'S NAME	DATE	DATE OF BIRTH

CONSENT FOR DENTAL TREATMENT

DENTAL TREATMENT CONSENT

I request and authorize Dr. H. Bobby Garofalis & Associates, as well as other health care professionals on his staff, to perform or assist with 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

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. 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 and will be asked to assist with placing their child in such restraint.

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 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.

PARENT/GUARDIAN – *PRINT NAME PLEASE*	RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

DATE	INITIALS	REASON

NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal dental care operations such as quality assessments and physician certifications.

I have had the opportunity to understand *HRPD's Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my dental health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of *HRPD's Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or dental and healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

PARENT/GUARDIAN SIGNATURE	DATE