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: _(____)_____ **Primary email:** _____

PARENT INFORMATION

LEGAL GUARDIAN (I)

☐**Biological Mother** ☐**Biological Father** ☐**Other** _____

Name:_____

DOB:_____ **SS#:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Home: (___)_____ **Cell:** (____)_____

Work: (___)_____

Email: _____

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

Street Address: _____

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

LEGAL GUARDIAN (II)

☐**Biological Mother** ☐**Biological Father** ☐**Other** _____

Name:_____

DOB:_____ **SS#:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Home: (___)_____ **Cell:** (____)_____

Work: (___)_____

Email: _____

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

Street Address: _____

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

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

Is there a custody arrangement: ☐**YES** ☐**NO**

If there is a court order specifying custody arrangement for primary responsibility, you need to provide that documentation.

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Policy Holder: _____

Relation to the patient: _____

DOB:_____ **SS#:** _____

ID /Policy #: _____

Insurance Company Name:_____

Phone: (___)_____

☐**Employee Plan** ☐**Retiree** ☐**Self-funded** ☐**State/Medicaid**

Group No: _____

SECONDARY COVERAGE

Policy Holder: _____

Relation to the patient: _____

DOB:_____ **SS#:** _____

ID /Policy #: _____

Insurance Company Name:_____

Phone: (___)_____

☐**Employee Plan** ☐**Retiree** ☐**Self-funded** ☐**State/Medicaid**

Group No: _____

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. I affirm that my signature represents my agreement to all the terms mentioned above.

Parent/Guardian Signature:_____ **Relation to Patient:**_____ **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
☐ Fluoride Mouthwash	☐ Dental Floss:_____/week	☐ Brushing by Parent:____/day	Type of snacks:_____

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 medical conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	Blood- Circulatory	☐	☐	Gastrointestinal - Stomach	☐	☐	Muscles (TB)
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Prosthetic Valve & Joints
☐	☐	Eyes – Ears - Nose	☐	☐	Liver	☐	☐	Skin Throat
☐	☐	Respiratory	☐	☐	Tonsils - Adenoids			

Has your child been diagnosed and/or treated for any medical conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	ADD/ADHD	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	Arthritis	☐	☐	Hearing Problems	☐	☐	Sickle Cell Trait / Disease
☐	☐	Asthma / Reactive Airway	☐	☐	Heart Murmur / Defect / Surgery	☐	☐	Speech Disorder
☐	☐	Autism Spectrum	☐	☐	Hemophilia / Abnormal Bleeding	☐	☐	Spina Bifida
☐	☐	Blood Disorder / Anemia	☐	☐	Hepatitis - Type ___	☐	☐	Stomach / GI Disorders
☐	☐	Brain Injury	☐	☐	Immune Disorder / HIV / AIDS	☐	☐	Tonsillitis
☐	☐	Bronchitis	☐	☐	Kawasaki Disease	☐	☐	Tuberculosis (TB)
☐	☐	Cancer / Tumor / Leukemia	☐	☐	Kidney Problems	☐	☐	Venereal Disease
☐	☐	Cerebral Palsy	☐	☐	Liver Disease / Jaundice	☐	☐	Vision Problems
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Whooping Cough
☐	☐	Cleft Lip / Palate	☐	☐	Mental / Cognitive / Social Delay	☐	☐	Other _____
☐	☐	Congenital Birth Defects	☐	☐	Mouth Breathing	**ALLERGIES:**		
☐	☐	Cystic Fibrosis	☐	☐	Mumps	☐	☐	Drug: _____
☐	☐	Diabetes	☐	☐	Orthopedic Problems / Scoliosis	☐	☐	Food: _____
☐	☐	Diphtheria	☐	☐	Polio	☐	☐	Seasonal Allergies
☐	☐	Drug / Alcohol Abuse	☐	☐	Pregnant	☐	☐	Hives
☐	☐	Eating Disorder/Nutr.Deficiency	☐	☐	Premature / Low Birth Weight	☐	☐	Latex
☐	☐	Epilepsy/Seizures/Convulsions	☐	☐	Psychiatric Disorder	☐	☐	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

FINANCIAL POLICY

We would like to take this opportunity to thank you for choosing Hampton Roads Pediatric Dentistry for your family's pediatric dental needs. We will work very hard to ensure you and your family receive the best care possible with every effort being made to address all your cares and concerns

Insurance: As a courtesy for our patients we are happy to file dental claims for families with dental insurance. Treatment plans, insurance pre-authorization, spoken statements or filing insurance claims ***does not*** guarantee payment from your insurance. HRPD will make no more than 2 attempts to file and settle an insurance claim within 6 months from the date of service. 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. Therefore, please be informed that our staff will **never** guarantee coverage/payment by your insurance provider. If a service is considered not covered by your insurance company, the patient will be responsible for the remaining balance. If you do not agree with the denial, you must resolve the matter with your insurance company. HRPD does NOT file claims to Medical Insurance Policies.

Patient's Responsibility: Our doctors recommend treatment based on the patient's needs, not what the insurance will cover. It is the patient's responsibility to know and understand their own dental insurance plan and allowances. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Treatment costs, co-pays, deductibles and non-covered procedures are due at the time services are rendered. When insurance is involved, your remaining balance is due upon settlement of your insurance claim. 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 any services rendered and 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.

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, MasterCard, Discover, American Express and CareCredit (in selected locations). There is a $50 fee for any checks returned by the bank.

Past Due Accounts & Statements: Our billing office sends out monthly statements for all accounts with a balance. Unless prior arrangements have been made through our billing office, balances on accounts are payable when the statement is issued. After three statements have been sent regarding your account balance, we will sent a Final Notice stating that you have 10 days to reconcile your account or you will be sent to a third-party collection agency, where you will be financially responsible for all reasonable expenses incurred, including but not limited to, third party collection fees of 33%.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

_____ ***(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 theirs. 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 ***notarized*** 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. ***Please call the office if you are running late.***

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 two "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, if missed or cancelled a restorative appointment with less than a 24-hour notice, we reserve the right to charge a $40 broken appointment fee or dismiss the patient from our practice so that we can provide care to other patients. Should you fail to confirm your appointment at least 24 hours ahead, we reserve the right to double book your assigned time slot and discard your priority to be serviced in that appointment.
- **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.

_____***(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, court filing fees, and attorney fees. I affirm that my signature represents my agreement to all the terms mentioned above.

Patient's Name: _____ **DOB:** _____

Parent / Guardian Print Name: _____

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

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

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Notice of Privacy Practices
Acknowledgment and Consent

PATIENT'S NAME	DATE	DATE OF BIRTH

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/LEGAL GUARDIAN (*PRINT NAME*)	RELATIONSHIP TO PATIENT

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