Welcome to PDS:

Thank you for selecting our dental healthcare team. We strive to make each of child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's name _____

Nickname _____Sex _____

Birth date _____Age _____

School _____Grade _____

Email _____

Responsible Party

Name _____

Relationship _____

Address_____

City _____ State _____

Zip _____ Phone _____

How did you find out about our practice? _____

Who is responsible for making appointments?

Name _____ Best time to call _____

Home phone _____ Cell phone _____

Emergency Contact name/telephone(Close relative, neighbor, ect.) _____

Primary Insurance

Insured's name _____

Relationship _____

Birth date _____ SSN_____

Home phone _____ Work Phone _____

Cell phone _____ Email Address _____

Occupation _____ Employer _____

Insurance Company _____

I have or will be informed of my treatment plan and associated fees. I agree to be responsible for all charges that I consent to for dental services and materials not paid for by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted by law. I consent to Pediatric Dental Specialists of Williamsburg, Pllc's use and disclosure of my protected health information to carry out payment activities in connection with claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dental entity, Pediatric Dental Specialists of Williamsburg, Pllc.

X_____

Signature of Legal Guardian/Responsible Party Date

PEDIATRIC DENTAL SPECIALISTS, PLLC
INITIAL ORAL ASSESSMENT

Patient Name: _____ **Date:** _____
Patient/ Guardian name? _____
Reason for today's visit: _____

Medical History

1. Does your child have any **illnesses?** **YES / NO**
   If yes, please explain. _____
2. Has your child ever been **hospitalized?** **YES / NO**
   If yes, please explain. _____
3. Has your child had any **surgeries**? **YES / NO**
   If yes, please explain. _____
4. Date of last physical and regular **doctor's name?** _____
5. Are your child's **immunizations** up-to-date? **YES / NO**
6. Is there any significant **family medical history?** **YES / NO**
7. Are there any problems in the family with **general anesthesia?** **YES / NO**
   If yes, please explain. _____
8. Is your child taking any **medications** (prescription or OTC)? **YES / NO**
   If yes, please explain. _____
9. Does your child have any **allergies** to any foods or medications? **YES / NO**
   If yes, please explain. _____
10. Is your child exposed to **smoke?** **YES / NO**

Dental History

11. Is this your child's **first dental visit?** **YES / NO**
    If no, date of last visit and treatment. _____
12. Has your child had any **bad experiences** at the dental office before? **YES / NO**
    If yes, please explain. _____
13. How does your child react to **dental treatment?** **WELL** **ACCEPTIBLE** **FEARFUL/RESISTANT**
14. Has your child had any **injuries** to the face or teeth? **YES / NO**
    If yes, please explain. _____
15. Does your child have any **oral habits,** like sucking on objects or fingers? **YES / NO**
    If yes, please explain. _____
16. Is there **fluoride** in your drinking water? **YES / NO/ NOT SURE**
17. What **snacks** does your child eat most often? _____
18. Does your child take a **drink** to bed? **YES / NO**
    If yes, please explain. _____
19. Does your child have unrestricted access to **drinks** in a cup or bottle during the day? **YES / NO**
    If yes, please explain. _____
20. Does your child have a history of bad reactions to **local anesthetic?** **YES/ NO**
    If yes, please explain. _____

Does your child currently have or has had a history of any of the following: YES / NO

AIDS-HIV
Anemia
Arthritis
Asthma
Autism
Birth Control
Birth Defects
Bladder Problems
Bleeding Problems
Blood Disease
Blood Transfusion
Bone Problems
Bone Marrow Transplant
Brain Injury
Bruising Easily
Cancer
Cerebral Palsy
Chemotherapy/Radiation
Chicken Pox
Chronic Ear Infections
Cleft Lip/Palate
Cystic Fibrosis
Developmental Delay
Diabetes
Disease Affecting Normal Growth
Drug Addiction
Ear Stuffiness, Itching, Noises
Eating Disorders
Eczema
Emotional Difficulties
Epilepsy, Seizures or Convulsions
Eye Problems
Excessive Gagging
Fainting or Dizziness
Fever Blisters
Frequent Coughs/ Colds
Genetic Disorders
Growth and Development Problems
Headaches
Hearing or Speech problems
Heart Defect
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
Hydrocephaly
Hyperactivity/ADHD
Kidney Disease
Leukemia
Liver Disease
Loud Snoring
Measles/Mumps/Rubella
Mouth Breathing
Nutritional Deficiency
Oral Ulcers
Pain in Joints
Premature Birth
Problems with Anesthesia
Psychiatric Care
Reflux Disease
Rheumatic Fever
Scoliosis
Second- Hand Smoke Exposure
Sexually Transmitted Disease
Shunt Placement
Sickle Cell Anemia
Skin Problems
Stroke
Syndrome
Tonsil Problems
Tuberculosis
Whooping Cough

Currently being followed by a physician for any of the above? YES / NO

Name of physician and phone number: _____

Any other conditions not listed? _____

Parent /Guardian signature:_____ **Date:** _____

Pediatric Dental Specialists of Williamsburg, Pllc
213 Bulifants Boulevard, Suite B, Williamsburg, VA 23188
757.903.4525

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor o clinic for other health care services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative or managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.
We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

1. When a state or federal law mandates that certain health information be reported for a specific purpose;

2. For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices;

3. Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

4. Uses and disclosures for health oversight activities, such as licensing of doctors, for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

5. Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

6. Disclosures for law enforcement purposes; such as to provide information about someone who is or is suspected to a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

7. Disclosures to a medical examiner to identify a dead person or determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

8. Uses or disclosures for health related research;

9. Uses and disclosures to prevent a serious threat to health or safety;

10. Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.

11. Disclosures of de-identified information;

12. Disclosures relating to worker's compensation programs;

13. Disclosures of a "limited data set" for research, public health, or health care operations;

14. Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures;

15. Disclosures to 'business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS
We may call you or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/ or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your

Continued on the next page

Idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
THE LAW GIVES YOU MANY RIGHTS REGARDING YOUR HEALTH INFORMATION. YOU CAN:

1. Ask us to restrict our usages and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address shown at the beginning of this Notice.

2. Ask us to communicate with you in a confidential way, such as by phoning you a work rather than a home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address shown at the beginning of this Notice.

3. Ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address at the beginning of this Notice.

4. Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address shown at the beginning of this Notice.

5. Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment of health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address shown at the beginning of this Notice.

6. Get additional paper copies of the Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in a paper form already. If you want additional paper copies, send a written request to the office contact person at the address at the beginning of the Notice.

OUR NOTICE OF PRIVACY PRACTICES
By law, we must abide by the terms of this Notice to Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by Law. If we change this Notice, the new privacy practices will apply to your health information that we already have a well as to such information that we may generate in the future. If we change our Notice to Privacy Practices, we will post a new notice in our office and have copies available in our office.

COMPLAINTS
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.
FOR MORE INFORMATION
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of the Notice.

********** **AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**********
I authorize the professional office of Pediatric Dental Specialists, PLLC to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients}:

3. The purposes(s) for the release (if the authorization is initiated by the individual, it is permissible to state " at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.
When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as e/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FROM. I AM SIGNING THE CONSENT VOLNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Parent/Legal Guardian Signature: _____ Date: _____

NO SHOW POLICY

Due to the rising demand for appointments in our office, we have enacted a new NO SHOW policy. Please call to cancel or reschedule an appointment 24 hours in advance. We recognize that scheduling conflicts so occur, so please call us as soon as possible if this arises.

1. There will be no penalty for the first cancellation or no show within 24 hours of the appointment.
2. We will inactivate you for the 2nd no show as a patient of record and will provide you with access to our practice for 30 days of urgent care until you find another dental home.

Our front office attempts to contact all patients 2-3 days before their appointment. Unfortunately, missed or failed appointments contribute to inefficient scheduling, lost time and higher fees. If there is any change in address or phone number that may complicate contact with you, please inform our office as soon as possible. We are not responsible for missed appointments due to the inability to reach you.

Please understand that these policies are meant to keep our practice running smoothly and efficiently. They also help keep your treatment as affordable as possible and at a higher level of quality. If you have any questions about this policy, please feel free to contact us.

Sincerely Yours,

Pediatric Dental Specialists, PLLC

I acknowledge receipt of the No Show Policy

X_____

Parent/Legal Guardian Signature Date

Pediatric Dental Specialist Financial Policy

Pediatric Dental Specialist is happy to provide the best possible service both on a clinical and patient service level. Therefore, we will do our best to make your visit in our office as smooth as possible. Upon making your appointment with us we will collect your insurance information. This allows our staff to verify your dental benefits and give you an **ESTIMATE** as to what your dental plan may cover, time permitting. Please keep in mind this is only an **ESTIMATE.** Benefit/insurance companies will only give an estimate not a guarantee of payment. We will pass this information we have collected along to you to ensure you have adequate time to arrive prepared for your child's dental procedure. Your patient portion is due at this time of service. For your convenience, we accept **CASH, VISA, MASTERCARD, DISCOVER, and CARE CREDIT.** Once your dental procedure is complete we will file your insurance for you based on the information we have collected from you. Once we receive payment from your individual plan we will either send you a statement for any remaining balance or process a refund check in your account guarantor's name. Refund checks are processed approximately once a month. Although we do everything possible to ensure payment is processed in a timely manner we sometimes find it necessary to resubmit your insurance claim. This can delay payment. Since we do process billing statements on an individual bases, payment is due upon receipt of statement. All Delinquent accounts will be turned over to Transworld Systems for further collection activity. If your account must be submitted to Transworld Systems, a 33% service fee will be added to your remaining balance. **NOTE: If your insurance company does not reimburse Pediatric Dental Specialist after 2 submissions, you will be responsible for the remainder of the balance on your account.** Thank you for entrusting us for your child's dental care.

Signature:_____

Date:_____