HOLLYMEAD DENTAL ARTS

1538 Insurance Ln
Charlottesville, VA 22911

Patient Information

PATIENT NAME ____

ADDRESS ____

CITY ____________________ STATE __________ ZIP ______________

HOME NUMBER (   ) ____________ WORK NUMBER (   ) ______________

CELL NUMBER (   ) ____________ EMAIL______________________

PATIENT SS# ________________ DOB______________________

Insurance Information

POLICY HOLDER __________________ PATIENT RELATION ____________

POLICY HOLDER'S DOB ____________ POLICY HOLDER'S SS# ____________

POLICY HOLDER'S EMPLOYER ________________________________

INSURANCE COMPANY ________________________________

GROUP # ________________ ID #______________________

INSURANCE COMPANY PHONE #______________________________

Emergency Contact Information

EMERGENCY CONTACT __________________ PHONE # (   )__________

ADDRESS____

CITY ____________________ STATE____________ ZIP ______________

How did you hear about us? ________________________________

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____________
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ______________________________ Phone ______________

Child's History

Yes No

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .... 1. ❑ ❑
   If yes, please list: ______________________________
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ______________ 2. ❑ ❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: ______________ 3. ❑ ❑
4. How would you describe the child's eating habits? ______________________________
5. Has the child ever had a serious illness? If yes, when: _____________ Please describe: ______________ 5. ❑ ❑
6. Has the child ever been hospitalized? .... 6. ❑ ❑
7. Does the child have a history of any other illnesses? If yes, please list: ______________ 7. ❑ ❑
8. Has the child ever received a general anesthetic? .... 8. ❑ ❑
9. Does the child have any inherited problems? .... 9. ❑ ❑
10. Does the child have any speech difficulties? .... 10. ❑ ❑
11. Has the child ever had a blood transfusion? .... 11. ❑ ❑
12. Is the child physically, mentally, or emotionally impaired? .... 12. ❑ ❑
13. Does the child experience excessive bleeding when cut? .... 13. ❑ ❑
14. Is the child currently being treated for any illnesses? .... 14. ❑ ❑
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ______________ 15. ❑ ❑
16. Has the child had any problem with dental treatment in the past? .... 16. ❑ ❑
17. Has the child ever had dental radiographs (x-rays) exposed? .... 17. ❑ ❑
18. Has the child ever suffered any injuries to the mouth, head or teeth? .... 18. ❑ ❑
19. Has the child had any problems with the eruption or shedding of teeth? .... 19. ❑ ❑
20. Has the child had any orthodontic treatment? .... 20. ❑ ❑
21. **What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water
22. **Does the child take fluoride supplements?** .... 22. ❑ ❑
23. **Is fluoride toothpaste used?** .... 23. ❑ ❑
24. How many times are the child's teeth brushed per day? __________ When are the teeth brushed? ______________ 24. ❑ ❑
25. Does the child suck his/her thumb, fingers or pacifier? .... 25. ❑ ❑
26. At what age did the child stop bottle feeding? Age ___________ Breast feeding? Age ___________
27. Does child participate in active recreational activities? .... 27. ❑ ❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ______________________________ Date ______________

For completion by dentist
Comments ______________________________

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For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by______________________________
Date ______________________________

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Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Patient HIPAA Acknowledgment and Consent

Last Name: First Name: DOB:

Today's Date:

Notice of Privacy Practices

I acknowledge that I have been informed of Hollymead Dental Arts Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosure. I understand that I may contact the office if I have a question or complaint. I understand that I may request a copy of the Notice of Privacy Practices at any time. To the extent permitted by law. I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices.

Release of Information

I hereby permit Hollymead Dental Arts to release healthcare information for purposes of treatment, payment, or healthcare operations as discussed in the Notice of Privacy Practices. I understand that Hollymead Dental Arts may be required by federal, state, or local law to disclose health information. I permit Hollymead Dental Arts to release necessary health information for Special Situations as described in the Notice of Privacy Practices.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. I understand that I may add or remove individuals from this list at any time.

Name	Relationship	Contact Number

____

Patient/Guardian Signature

HOLLYMEAD DENTAL ARTS

Patient Financial Responsibility

I, ______________________________ hereby assign to Hollymead Dental Arts all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge than any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Hollymead Dental Arts thereafter receives payment from my insurance company I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s) my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

This office participates as "Dental Providers" for Guardian, Delta Dental Premier, United Concordia, Cigna Radius, Anthem, and Metlife. If you have dental insurance with companies other than those listed above you will be responsible for your co-payment **TODAY** according to your dental insurance plan. We will submit today's visit to your insurance company.

- I agree to pay interest on the total unpaid monthly balance at the rate of 18.00% APR, such interest to begin if the account is thirty (30) days past due and calculated from the date of service.
- I agree to pay all cost of collections, including, but not limited to thirty-five percent (35%) collection fees and attorney fees of thirty-three percent (33%), but not less than $200.00, regardless if suit is filled or not, as well as, all court costs.
- I understand Hollymead Dental Arts **DOES NOT** accept postdated checks.
- I understand Hollymead Dental Arts **DOES NOT** accept payment plans and payment is expected at every appointment unless otherwise stated.
- Broken, missed, or cancelled appointments without 24 hours prior notification will be charged a missed appointment fee of $75.00.
- **I will pay any expected deductible and co-insurance amounts today and at each future office visit.**

We are a medical practice and as such we will ask you to complete a Health History Form. We will ask you for updates of your personal and medical information. It is important to us and to your treatment here. Your cooperation in completing this information is appreciated.

THERE WILL BE A FEE OF $35 FOR ALL RETURNED CHECKS

______________________	______________________	__________
PRINT NAME (PATIENT)	SIGNATURE OF RESPONSIBLE PARTY	DATE