Health History Form

Print this form, complete all information, and bring it with you on your first visit to our office.
The parent or Guardian who accompanies the child is responsible for payment at the time of service.

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
703-942-8404 703-890-8726

DEL RAY
609 East Monroe Ave, Alexandria, VA 22301
703-341-4418 703-649-3521

1 Tell Us About Your Child

Child's Name:

Last First MI

Nickname

Child's Birthdate / /

Male Female

Siblings that we treat:

Email Address:

Home Address:

State City Zip

Child's School:

2 Whom may we thank for referring you to our office?

3 Who is Accompanying the Child Today?

Name

Relationship

Do you have legal custody of this child?

Yes No

Office Use Only Patient Name:

4 Mother's Information

Name

Mother Stepmother Guardian

Birthdate / /

Employer

Work Phone /

Home Phone /

Mobile Phone /

5 Father's Information

Name

Father Stepfather Guardian

Birthdate / /

Employer

Work Phone /

Home Phone /

Mobile Phone /

6 Child's Physician

Name

Phone /

Is the child currently under the care of a physician for a specific health issue? Yes No

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

Good Fair Poor

Health History Form

Print this form, complete all information, and bring it with you on your first visit to our office.
The parent or Guardian who accompanies the child is responsible for payment at the time of service.

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
703-942-8404 703-890-8726

DEL RAY
609 East Monroe Ave, Alexandria, VA 22301
703-341-4418 703-649-3521

7 Primary Dental Insurance

Insurance Co. Name

I. Co. Phone /

Group

Member

Policy Holder's Name

Relationship to Patient

Policy Holder's Birthdate / /

Social Security

Policy Holder's Employer

8 Secondary Dental Insurance (IF ANY)

Insurance Co. Name

I. Co. Phone /

Group

Member

Policy Holder's Name

Relationship to Patient

Policy Holder's Birthdate / /

Social Security

Policy Holder's Employer

Office Use Only Patient Name:

9 Dental History

Is this your child's first visit to the dentist? Yes No

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

Any x-rays taken at previous dental visits? Yes No

Have there been any injuries to the teeth, face or mouth? Yes No

If yes, please explain

Why did you bring the child to the dentist today?

Does the child have any of the following habits?

Lip Sucking / Biting Yes No

Nail Biting Yes No

Nursing / Bottle Habits Yes No

Thumb / Finger Sucking Yes No

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

If yes, please explain

Is the child currently in pain? Yes No

Has the child ever had any pain or tenderness inhis/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

What is your child's temperment?

Friendly Shy Nervous Scared Willed

Health History Form

Print this form, complete all information, and bring it with you on your first visit to our office.
The parent or Guardian who accompanies the child is responsible for payment at the time of service.

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
703-942-8404 703-890-8726

DEL RAY
609 East Monroe Ave, Alexandria, VA 22301
703-341-4418 703-649-3521

10 Does the child currently have or has the child ever had any of the following conditions?

Abnormal Bleeding	Yes ☐	No ☐
Allergies to any Drugs	Yes ☐	No ☐
Any Hospital Stays	Yes ☐	No ☐
Any Operations	Yes ☐	No ☐
Autism Spectrum Disorder	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
ADHD/ADD	Yes ☐	No ☐
Hay Fever/Seasonal Allergies	Yes ☐	No ☐
Emotional Problems	Yes ☐	No ☐
Sensory Disorder	Yes ☐	No ☐
Speech Delays	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Cerebral Palsy	Yes ☐	No ☐
Congenital Birth Defects	Yes ☐	No ☐
Convulsions/Epilepsy	Yes ☐	No ☐
Developmental Delays	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Down's Syndrome	Yes ☐	No ☐
Pregnancy	Yes ☐	No ☐
Handicaps/Disabilities	Yes ☐	No ☐
Hearing Impairment	Yes ☐	No ☐
Heart Disease/Murmur	Yes ☐	No ☐
Hemophilia/Blood Disorders	Yes ☐	No ☐
Sickle Cell Anemia/Trait	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐
HIV+/AIDS	Yes ☐	No ☐
Kidney/Liver Conditions	Yes ☐	No ☐
Rheumatic/Scarlet Fever	Yes ☐	No ☐
Allergies to Latex Product	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐

Office Use Only Patient Name:

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:

Please list any other allergies:

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

Print Name

Relationship to Patient

Date / /

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

For Office Use Only. Doctor's Comments.

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

Drs. Initials Date / /

Save Print Email

alexandria children's dentistry

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
703-942-8404 703-890-8726

DEL RAY
609 East Monroe Ave, Alexandria, VA 22301
703-341-4418 703-649-3521

We are committed to providing your child with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are provided unless payment arrangements have been approved in advance by our office manager or business assistant. We accept cash, check, Visa, Mastercard and Care Credit. We will be happy to help you process your insurance claim for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit.

We will gladly discuss your child's proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a deductible that must be met before the company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until the deductible is met. Even after the deductible is met, most companies still only pay a percentage (such as 50% or 80%) up to the maximum yearly allowance and you will be responsible for the remainder.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are provided.

If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us; we are here to help you.

Who is financially responsible for this bill? _____

I will be paying today by: Cash ☐ Check ☐ Credit Card ☐ Care Credit ☐ Insurance ☐

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services provided. I have read and understand the above information

Parent's or Guardian signature _____ Date ____ / ____ / ____

alexandria children's dentistry

OFFICE POLICY AND CONSENT FORM

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
703-942-8404 703-890-8726

DEL RAY
609 East Monroe Ave, Alexandria, VA 22301
703-341-4418 703-649-3521

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT. For treatment involving fees above $500.00, special financial arrangements may be discussed with our office manager.

- For patients with Dental Insurance:
  We will file your claim for you at no charge, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility. All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

- Please note for your convenience, we do accept VISA, MasterCard, Discover, and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we would appreciate a 48-hour notice. Repeated cancellations or failures could result in a broken appointment charge or no reappointment.

- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.

- We will be fair in working out special finances with you, but please also be fair to us with your commitments. If for any reason your account is sent to a third party (collections) due to non-payment, there will be a 25% fee of the balance added to your account.

OFFICE POLICIES

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.

Parent's or Guardian signature _____ Date ____ / ____ / _____

PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
t 703-942-8404 f 703-890-8726

DEL RAY
609 East Monroe Ave, Alexandria, VA 22301
t 703-341-4418 f 703-649-3521

State law requires that health professional provide their prospective patients with information regarding the treatment or procedures they are contemplating. State law also requires them to obtain consent for specific dental treatment, procedures or techniques which might be considered to be of concern to the patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. All efforts are made to maintain the cooperation of young patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding. There are several behavior management techniques that are recommended by the American Academy of Pediatric Dentistry and used by pediatric dentists to gain the cooperation of children to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The following techniques may be used, however, the first five techniques are preferred and used most frequently. The last two management techniques are used much less often and only after all management techniques have been attempted but the child's behavior is disruptive and could cause harm to themselves.

1. Tell-show-do : The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model, or the child's or dentist's finger. The procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. Positive reinforcement : This technique rewards the child who displays any behavior which is desirable. Examples of rewards include compliments, encouragement, praises, or prizes.
3. Voice Control : The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
4. Nitrous Oxide "laughing gas" : Only used with additional verbal and written parental consent. Some children are administered nitrous oxide to relax them for their dental treatment. Nitrous oxide is given through a small breathing mask which is placed over the child's nose, allowing them to relax, but without putting them to sleep. As soon as the mask is removed, the effects of the nitrous oxide diminish within five minutes.
5. Mouth Props "tooth pillow": A soft, rubber device used to assist the child in keeping their mouth open during a procedure.
6. Protective stabilization by the dentist--Very rarely used (only if absolutely necessary with additional verbal parental consent): The dentist gently protects the child from movement by holding the child's hands/ or upper body, stabilizing the child's head or positioning the child safely in the dental chair.
7. Protective stabilization by the assistant--Very rarely used (only if absolutely necessary with additional verbal parental consent): The assistant gently protects the child from movement by holding the child's hands, stabilizing their head, and/or controlling leg movements

I hereby authorize Dr. Angela Austin and/or auxiliary, to utilize the behavior management techniques listed on this form to assist in the provision of necessary dental treatment. I hereby acknowledge that I have read and understand this consent form, that I have been given the opportunity to ask any questions I might have about the behavior management techniques or the procedures to be performed now, or whenever the behavior management techniques are used.

This consent to treatment will remain in effect until I choose to terminate it.

Date ____ / ____ / ____

Parent's or Guardian signature

Witness Signature

Save Print Email

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM

LANDMARK
6303 Little River Turnpike Alexandria, VA 22312
703-942-8408 703-890-8726

DEL RAY
609 East Monroe Ave Alexandria, VA 22301
703-341-4418 703-649-3521

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUESTTREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

I, _____ , have received a copy of this office's

Notice Of Privacy Practices.

Patient's Name Please Print _____

Signature of Patient (Parent or Guardian if Child) _____

Date ____ / ____ / _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

LANDMARK
6303 Little River Turnpike, Alexandria, VA 22312
703-942-8404 703-890-8726

DEL RAY
609 East Monroe Ave Alexandria, VA 22301
703-341-4418 703-649-3521

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Text message to my Cell Phone
- ☐ Home Phone Confirmation
- ☐ Email Confirmation
- ☐ Work Phone Confirmation
- ☐ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Home Phone Confirmation
- ☐ Email Confirmation
- ☐ Work Phone Confirmation
- ☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ Any of the Above
- ☐ None of the Above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

FOR OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's for representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe): _____

Signature of Privacy Officer _____