Beach Kids Dentistry

A Division of Atlantic Dental Care, PLC
1300 Kempsville Road, Suite 5, Virginia Beach, VA 23464
Office: 757-467-7797 / Fax: 757-474-1493 / www.BeachKidsDental.com

NEW PATIENT SOCIAL AND INSURANCE INFORMATION

This record is confidential and for use only within this office.

PATIENT INFORMATION

Patient Name*_____ Preferred Name _____
Birth Sex: Male Female Current Gender Identity:_____ Race/Ethnicity:_____ Date of Birth*_____ Age_____
Address*_____ City_____ State_____ Zip_____
Best Contact Phone*_____ School_____ Grade_____
Whom does the child live with? _____
How did you hear about our practice? _____

GUARDIAN INFORMATION

Name*_____ Relationship to Patient*_____ Date of Birth*_____
Address*_____ City*_____ State*_____ Zip*_____
SSN*_____ Home Phone_____ Work Phone_____ Cell Phone*_____
Email*_____ Employer_____

Name_____ Relationship to Patient_____ Date of Birth_____
Address_____ City_____ State_____ Zip_____
SSN_____ Home Phone_____ Work Phone_____ Cell Phone_____
Email_____ Employer_____

Name_____ Relationship to Patient_____ Date of Birth_____
Address_____ City_____ State_____ Zip_____
SSN_____ Home Phone_____ Work Phone_____ Cell Phone_____
Email_____ Employer_____

Name_____ Relationship to Patient_____ Date of Birth_____
Address_____ City_____ State_____ Zip_____
SSN_____ Home Phone_____ Work Phone_____ Cell Phone_____
Email_____ Employer_____

DENTAL INSURANCE INFORMATION

Primary

Subscriber_____ Relationship to Patient_____ Date of Birth_____
Employer_____ Group #_____ SSN or ID#*_____
Insurance Provider _____ Ins. Phone_____ Ins. Address_____

Secondary

Subscriber_____ Relationship to Patient_____ Date of Birth_____
Employer_____ Group #_____ SSN or ID#_____
Insurance Provider_____ Ins. Phone_____ Ins. Address_____

AUTHORIZATION TO TREAT

I, being the parent or guardian of the above minor patient, hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures the dentist may deem necessary during treatment. I understand that the dentist and designated assistants treating the above patient will use restorative, oral surgery, and patient management techniques that are reasonable, necessary, and advisable. I authorize the administration of anesthetics or analgesics which may be deemed advisable by the dentist. I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. I grant permission to use clinical photographs in scientific journals and lectures.

I accept responsibility for full payment of all dental services performed on the above-named patient. The parent or guardian bringing the patient to our office is responsible for payment of the account. Insurance co-payments are due at the time of service. The insurance will be filed promptly, but the remaining account balance must be paid in full within 30 days, regardless of whether the insurance company has paid or not. Delinquent accounts over 60 days will incur 1.5% per month finance charge. If the account is referred for collection, the parent or guardian will be responsible for the balance plus the attorney's fees which is 25% of the remaining balance.

Signature of Parent or Guardian*_____ **Date***_____

Beach Kids Dentistry

A Division of Atlantic Dental Care, PLC
1300 Kempsville Road, Suite 5, Virginia Beach, VA 23464
Office: 757-467-7797 / Fax: 757-474-1493 / www.BeachKidsDental.com

NEW PATIENT HEALTH HISTORY

This record is confidential and for use only within this office.

Patient's Legal Name:*_____ Preferred Name:_____

Primary Care Physician: _____ Phone: _____ Last Visit: _____
Medical Specialists:_____ Phone: _____ Last Visit: _____

MEDICAL HISTORY

Is your child being treated by a physician at this time? Reason_____	__Yes	__No
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?.....	__Yes	__No
List name, dose, frequency, date started_____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?...	__Yes	__No
List date and describe_____		
Does your child require an antibiotic (SBE) prior to dental visits?.....	__Yes	__No
Has your child ever had a reaction to or problem with an anesthetic? Describe_____	__Yes	__No
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List_____	__Yes	__No
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	__Yes	__No
Is your child up to date on immunizations against childhood diseases?	__Yes	__No
Is your child immunized against human papilloma virus (HPV)?.....	__Yes	__No

Please mark YES if your child has a history of the following conditions. For each "Yes", provide details on the lines provided at the end of the medical questions. Mark NO after each line if none of those conditions apply to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions.....	__Yes	__No
Problems with physical growth or development.....	__Yes	__No
Sinusitis, chronic adenoid/tonsil infections.....	__Yes	__No
Sleep apnea/snoring, mouth breathing, or excessive gagging.....	__Yes	__No
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease.....	__Yes	__No
Irregular heartbeat or high blood pressure.....	__Yes	__No
Asthma, reactive airway disease, wheezing, or breathing problems.....	__Yes	__No
Cystic Fibrosis.....	__Yes	__No
Frequent colds or coughs, or pneumonia.....	__Yes	__No
Frequent exposure to tobacco smoke.....	__Yes	__No
Jaundice, hepatitis, or liver problems.....	__Yes	__No
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems.....	__Yes	__No
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions.....	__Yes	__No
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder.....	__Yes	__No
Bladder or kidney problems.....	__Yes	__No
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis.....	__Yes	__No
Rash/hives, eczema, or skin problems.....	__Yes	__No
Impaired vision, visual processing, hearing, or speech.....	__Yes	__No
Developmental disorders, learning problems/delays, or intellectual disability.....	__Yes	__No
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures.....	__Yes	__No
Recurrent or frequent headaches/migraines, fainting, or dizziness.....	__Yes	__No
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoarterial, ventriculovenous).....	__Yes	__No
Autism/autism spectrum disorder.....	__Yes	__No
Attention deficit/hyperactivity disorder (ADD/ADHD).....	__Yes	__No
Behavioral, emotional, communication, or psychiatric problems/treatment.....	__Yes	__No
Abuse (physical, psychological, emotional, or sexual) or neglect.....	__Yes	__No
Diabetes, hyperglycemia, or hypoglycemia.....	__Yes	__No
Precocious puberty or hormonal problems.....	__Yes	__No
Thyroid or pituitary problems.....	__Yes	__No
Anemia, sickle cell disease/trait, or blood disorder.....	__Yes	__No

Hemophilia, bruising easily, or excessive bleeding..... __ Yes __ No
Transfusions or receiving blood products..... __ Yes __ No
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant..... __ Yes __ No
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), MRSA, sexually transmitted disease (STD), HIV/AIDS. __ Yes __ No
PROVIDE DETAILS HERE _____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told?..... __ Yes __ No
If YES, describe_____

DENTAL HISTORY

What is your primary concern about your child's oral health?_____
How would you describe:
Your child's oral health? __ Excellent __ Good __ Fair __ Poor
Your oral health? __ Excellent __ Good __ Fair __ Poor
The oral health of your other children? __ Excellent __ Good __ Fair __ Poor __ Not applicable
Does your child have a history of any of the following? For each YES response, please describe:
Inherited dental characteristics __ Yes __ No _____
Mouth sores or fever blisters __ Yes __ No _____
Bad breath __ Yes __ No _____
Bleeding gums __ Yes __ No _____
Cavities/decayed teeth __ Yes __ No _____
Toothache __ Yes __ No _____
Injury to teeth, mouth, or jaws __ Yes __ No _____
Clinching/grinding his/her teeth __ Yes __ No _____
Excessive gagging __ Yes __ No _____
Sucking habit after age 1 __ Yes __ No If YES, which: __ Finger __ Thumb __ Pacifier __ Other How long?_____
How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? __ Yes __ No
How often does your child floss his/her teeth? _____ times per _____ Does someone help your child floss? __ Yes __ No
What toothpaste does your child use?_____
What is the source of your drinking water at home? __ City/community water __ Private well __ Bottled water
Please check all sources of fluoride your child receives:
__ Drinking water __ Toothpaste __ Over the counter rinse __ Prescription rinse/gel __ Prescription drops/tablets/vitamins
__ Fluoride treatment in the dental office __ Fluoride varnish by pediatrician/other practitioner __ Other: _____
Is your child on a restricted diet? __ Yes __ No If YES, describe:_____
Does your child have a diet high in sugars or starches? __ Yes __ No If YES, describe:_____
How frequently does your child have the following?
Snacks between meals __ Rarely __ 1-2 times/day __ 3 or more times/day Product_____
Candy or other sweets __ Rarely __ 1-2 times/day __ 3 or more times/day Type_____
Soft drinks* __ Rarely __ 1-2 times/day __ 3 or more times/day Product_____
*(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)*
Please note any other significant dietary habits:_____
Does your child participate in any sports or similar activities? __ Yes __ No If YES, please list_____
Does your child wear a mouthguard during these activities? __ Yes __ No If YES, type_____
Has your child been examined or treated by another dentist? __ Yes __ No
If YES: Date of first visit:_____ Date of last visit:_____ Reason for last visit:_____
Were x-rays taken of the teeth or jaws? __ Yes __ No Date of most recent dental x-rays:_____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances? __ Yes __ No If YES, when?_____
Has your child ever had a difficult dental appointment? __ Yes __ No If YES, describe:_____
How do you expect your child will respond to dental treatment? __ Very well __ Fairly well __ Somewhat poorly __ Very poorly
Is there anything else we should know before treating your child? __ Yes __ No
If YES, describe:_____

Signature of parent/guardian*_____ Relationship to patient*_____ Date*_____

(Staff_____)

Beach Kids Dentistry

Operating Division of Atlantic Dental Care, PLC

Privacy Official: Maria Rasmussen: 1300 Kempsville Road, Suite 5, Virginia Beach, VA 23464 / Office: 757-467-7797 / Fax: 757-474-1493 / www.beachkidsdental.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights, and we have certain legal obligations regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice. "Protected Health Information" or "PHI" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your health information in the following circumstances:

Treatment: We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (i.e., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service. Normal and routine medical history, dental treatment, scheduling appointments and insurance information may be discussed in the reception area, front desk, and the clinical areas of the office. Our patient files are stored in unlocked file cabinets. Daily schedules of patient care are posted in various areas within the office.

Payment: We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, emails, texts, postcards, or letters. We also may use and disclose Health information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. For example, health care operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may use and disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your child's care. Additionally, we may disclose information about your child's PHI to a patient representative. If a person has the authority by law to make health care decisions for your child, we will treat that patient representative the same way we would treat you with respect to your child's health information. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Required by Law: We may use or disclose your health information when we are required to do so by international, federal, state, or local law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Marketing/Social Media: We will not use your health information for marketing or social media communications without your written authorization.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. You have the right to opt out of receiving fundraising communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Research: We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

To Avert a Serious Threat to Health or Safety: We may use and disclose your PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates: We may disclose your PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

Organ and Tissue Donation: If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may use or disclose your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose your PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence: We may disclose your PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Other Uses and Disclosures of PHI

Your authorization is required for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization: 1. Most uses and disclosures of psychotherapy notes; 2. Uses and disclosures of PHI for marketing purposes; and 3. Disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Protected Health Information Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of the Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Right to an Accounting of Disclosures: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request the accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Right to Request an Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with an explanation of why we denied it and explain your rights.

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our website or by electronic mail (email).

How to Exercise Your Rights: To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your PHI, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice: We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints: You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

A Division of Atlantic Dental Care, PLC
1300 Kempsville Road, Suite 5, Virginia Beach, VA 23464
Office: 757-467-7797 / Fax: 757-474-1493 / www.beachkidsdental.com

RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Patient Name: _____

Parent/Guardian Signature: _____

Date: _____

The practice may discuss your child's treatment with the following individuals:

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other: _____

_____

Jessica M. Clark, DDS
1300 Kempsville Road, Suite 5, Virginia Beach, VA 23464
Office: 757-467-7797 / Fax: 757-474-1493 / info@beachkidsteeth.com
www.BeachKidsDental.com

Beach Kids DENTISTRY

OFFICE GUIDELINES AND PROCEDURES

Welcome to Beach Kids Dentistry! Our mission is to treat families like our own in a fun, safe, and trustworthy environment. We will provide quality care so our team will be your family's first choice for pediatric dentistry. In order to provide the highest quality care, we ask that parents/guardian follow our office guidelines and procedures.

PLEASE INITIAL EACH LINE BELOW:

_____ **PARENTAL PRESENCE:** To provide comprehensive care for your child, we need to focus on their needs during scheduled appointments. The parent is welcome to join their child during appointments; however, we encourage children to be independent and come back alone as this facilitates better communication and establishes life-long rapport. If you would like to accompany your child, we ask that only one adult escort the child to the clinical area. For their safety, siblings or other children must remain in the waiting area with a supervising adult.

_____ **PHOTO/VIDEO RECORDINGS:** Due to the safety and privacy of other patients and families, photographs, video, and audio recordings are not permitted in the treatment area. Please ask our team members for a "photo-op" area if pictures are desired.

_____ **DENTAL INSURANCE:** We file dental insurance as a courtesy to our patients. We are not responsible, nor can we guarantee what benefits your insurance company will pay on a claim. We do not guarantee in-network status with your insurance plan. You must contact your dental insurance company for eligibility or in-network verification. We can assist you in estimating your portion of the cost of treatment. It is your responsibility to keep us informed of any insurance changes such as policy name, insurance company, or change of employment. You are responsible for balances not covered by your insurance plan.

_____ **PAYMENT:** Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan which fits your timetable and budget, and gives your child the best possible care. We accept Cash, Personal Checks, Care Credit, and most Major Credit Cards. Payment is required at the time of service regardless of who brings the child.

_____ **APPOINTMENT CANCELLATIONS:** Out of respect for our professional time and for other families, we request 48-hour advanced notification for any cancellations or rescheduling. Failure to notify of appointment cancellation or broken appointment will result in notification from the office and possible dismissal from the practice.

_____ **LATE ARRIVAL:** Arriving late to a scheduled appointment may result in longer than expected wait times or potential cancellation.

I have read and understand the office guidelines and procedures. Following these guidelines will help the team members provide the highest quality of care for my child in a fun and safe environment.

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