KINGSTOWNE
DENTAL SPECIALISTS
5911 Kingstowne Village Pkwy #150
Alexandria, VA 22315
Phone: 703.493.0622
Fax: 703.215.1262

Patient Name:

Date of Birth:

Reason for Today's Visit:

In order to ensure that your child receives the best care at our practice, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name:_____ Nickname:_____ Sex:_____

Age: _____ Birthdate:_____ Interests/Hobbies/Pets: _____

Mailing Address:_____ City: _____ State: _____ Zip:_____

Home Telephone: _____ Parent's Mobile Phone: _____

Parent Email(s): _____

May we contact you through email? Yes☐ or No ☐

Responsible Party: _____

Parent/Guardian 1 Name: _____

Parent/Guardian 2 Name: _____

Parent's Address (if not living at above) _____

Who has legal custody of patient: ☐Mother ☐ Father ☐ Joint ☐ Other ☐

What is the parent's primary language? _____ The child's? _____

Date of Adoption, if applicable: _____

Names and ages of brothers and sisters: _____

How did you hear about us? _____

If the referral was from a Physician/Pediatrician/Dentist, please name the practice: _____

Whom may we contact in case of emergency?

Name: _____ Relationship: _____ Phone: _____

HEALTH PROVIDERS

Child's Physician/Pediatrician: _____ Phone#: _____

Mailing Address: _____ City: _____ State:_____ Zip: _____

Child's Previous Dentist: _____ Phone#: _____

Mailing Address: _____ City: _____ State:_____ Zip: _____

Patient Name: _____

DENTAL HISTORY

1. If your child has been to a dentist previously:

When was last visit? _____ Have X-rays been taken? ☐Yes ☐No When: _____

2. How did your child react?_____

3. Has your child had local anesthetic ("Novocaine"?) ☐Yes ☐No

Were there any problems? _____

4. How old was your child when his/her first tooth erupted? _____

5. Fluoride: Has your child had fluoride in any of the following forms:

Fluoride tablets or fluoride multivitamins……... ☐Yes ☐No

If yes, at what age did he/she start taking them? _____ Is he/she still taking them? ☐Yes ☐No

Drinking water (community/tap water fluoridation)……... ☐Yes ☐No

Professional topical application…….. ☐Yes ☐No

6. Brushing: Does your child brush his/her own teeth?…...……...…… ☐Yes ☐No

When does he/she brush? ☐A.M. ☐P.M. ☐After meals

Do you help in brushing your child's teeth?…… ☐Yes ☐No

How much toothpaste does your child use? _____ Does he/she swallow it? ☐Yes ☐No

Do you or your child use dental floss in cleaning their teeth?…… ☐Yes ☐No

How often? _____

What kind of toothbrush does he or she use? ☐Hard ☐Soft ☐Battery

7. Diet: Does your child snack frequently?……...……... ☐Yes ☐No

What do those snacks consist of and how often?_____

How much soda and juice does your child usually drink per day? _____

Was/is your child allowed to carry a bottle/cup throughout the day containing something other than plain water? ☐Yes ☐No

8. Trauma: Have your child's teeth ever been injured?..... ☐Yes ☐No

When (age)? _____

Which teeth? _____

Cause? _____

Did he/she receive treatment?…… ☐Yes ☐No

If yes, describe treatment _____

9. Habits: Does your child have any of the following habits? (Indicate inclusive ages)

Bottle to sleep or nap containing _____ ☐Yes ☐No

Thumb or finger sucking (which thumb/finger _____) ☐Yes ☐No

Pacifier sucking……...……...…… ☐Yes ☐No

If yes, is it ever dipped in honey or other sweet substances? …… ☐Yes ☐No

Mouth Breathing…….…… ☐Yes ☐No

Grinding of teeth…… ☐Yes ☐No

10. Has your child received any unusual dental or surgical treatment to the mouth? ☐Yes ☐No

If yes, describe: _____

11. Is there anything else you would like to tell us regarding your child's dental health?

_____

_____

Patient Name:_____

MEDICAL HISTORY

12. Where there any difficulties during the pregnancy, delivery (e.g., prematurity) or 1st year of your child's life? If yes, describe?_____ ☐Yes ☐No

13. Medical conditions: Does your child have any history of the following? *(Check all that apply)*

General conditions	***Developmental***	***Infectious***
☐Arthritis	☐Brain injury	☐Hepatitis
☐Asthma	☐Cerebral palsy	☐HIV infection (AIDS)
☐Diabetes	☐Cleft lip/palate	☐Tuberculosis
☐Gastrointestinal disorders	☐Developmental Delay	☐Venereal disease:
☐Heart disease	☐Feeding/Eating problems	Type_____
☐Heart murmur	☐Growth problems	
☐Kidney disease	☐Hearing loss: Type _____	***Substance use/Abuse***
☐Rheumatic fever	☐Neuromuscular defect	☐Drug use
	☐Orthopedic problems	☐Tobacco use
Behavior/Learning	☐Seizures: Type_____	☐Abuse (physical or sexual)
☐ADHD	☐Speech prob: Type _____	
☐Anxiousness/Nervousness	☐Spina bifida	***Other***
☐Autism		☐Cancer: Type _____
☐Behavior issues: Type_____	***Hematological (Blood-related)***	☐Leukemia: Type _____
☐Emotional disability:	☐Anemia	☐Fainting/headaches (often)
Type_____	☐Bleeding (prolonged)	☐Sleep apnea
☐Learning disability:	☐Hemophilia	☐Sleep problems
Type_____	☐Sickle cell trait	☐Snoring
☐Psychiatric disorder:	☐Sickle cell disease	☐Syndrome: Type _____
Type_____	☐Transfusion of blood	☐Other: _____

If any boxes checked, please describe further:_____
_____
_____

14. Medications: Is your child CURRENTLY taking any medications?

Drug	How much & how often?	Reason

15. Steroid Use: Has your child had any steroid treatment in the past 6 months? …….. ☐Yes ☐No

16. Allergies: Has your child had any allergic reactions to:

Medications or drugs? _____
Latex?_____
Foods? _____
Other? _____

Patient Name:_____

17. Development/ Special needs:

Can your child talk and understand at his/her age level?……..…… ☐Yes ☐No
Does your child attend a special class or school? If yes:_____ ☐Yes ☐No
Does your child use the following to help with walking? ☐Wheelchair ☐Walker ☐Other
If female, has your child had her first monthly period?…….…… ☐Yes ☐No

18. Immunizations: Are your child's immunizations current?……. …… ☐Yes ☐No

19. Have you ever been told that your child needs to take *antibiotics before dental treatment*? ☐Yes ☐No

20. Hospitalizations: Has your child ever been hospitalized?…….. ☐Yes ☐No
……..

If yes, when, and where? _____
Reason for hospitalization? _____

21. Surgeries: Has your child had any surgery (operations)?…….. ☐Yes ☐No
Date(s) and age(s)? _____
For what reason(s)? _____
Was general anesthesia used?…….. ☐Yes ☐No
Were there any complications? If yes: _____ ☐Yes ☐No

22. Are there any elevated stresses happening in your home? If yes:_____ ☐Yes ☐No

23. Have you or your child ever felt threatened in your home?……. ☐Yes ☐No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Name: _____

Signature: _____Relationship to patient:_____Date:_____

***Reviewed by*: Doctor_____Date:_____**

CONSENT FOR DENTAL TREATMENT

I am the parent, guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Marzban and her staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, any necessary dental treatment for my child's teeth,X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Marzban, whether or not I am present when the treatment is rendered. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Marzban will provide an environment that will help children learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charges incurred for my child for dental treatment.

Signature:_____ Date:_____

_____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

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FINANCIAL AGREEMENT

We believe that our Patient Financial Agreement is as important as the services that we perform. It is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and a dental insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the dental insurance company, and not the dental office. The goal of most dental insurance policies is to provide only basic care for specific dental services and typically have little to do with your child's needs or achieving a high-quality, complete result. Many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your dental benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. **Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your dental insurance policy so that you are fully aware of coverage and any limitations of the benefits provided.** If an exact determination makes you more comfortable, the best method for accuracy is to pre-authorize the procedures with your carrier. We want our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment.

Dr. Marzban and her staff are committed to providing excellent dental care and guiding parents in choosing the best payment option for their child's needs. We accept cash, personal checks, Visa, MasterCard, American Express, Discover, as well as offer Capital One Health Care Financing (a dental credit card). If paying by check, there will be a charge of $25 for any check that is returned due to insufficient funds. A check returned due to NSF may require a credit card number to be placed on file for future payments.

BROKEN APPOINTMENT POLICY

The time for your child's dental appointment has been exclusively reserved for you and your child. Without proper notification of your inability to be present for an appointment, some other child who has been waiting for dental care will not receive the dental care they need because we did not have adequate time to notify them of the available time. Therefore, we are requiring that at least **24 hours** notice be given, as a courtesy to us and to other patients, if your scheduled time is inconvenient. **The Broken Appointment fee will be $75, unless otherwise noted. Also, if you arrive to your appointment ten minutes late we reserve the right to reschedule your appointment.**

The patient and/or responsible party have received, read, and understand the financial agreement and broken appointment policies. The patient and/or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contracted agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be covered service by third party insurers or payors.

I agree that balances over 45 days be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for any outstanding claims. This consent will remain in effect unless cancelled in writing.

Child (ren)'s name:_____

Name of parent/guardian:_____

Signature:_____ Date:_____

Credit Card: MC VISA AMEX Discover #_____ Exp:_____

Office Witness Signature: _____ Date: _____

KINGSTOWNE
DENTAL SPECIALISTS

HIPAA PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility.

Please Initial and Sign:

_____ In accordance with HIPAA regulations (refer to laminated forms), I understand that this information will be held in strict confidence. I hereby give my permission for the office of Kingstowne Dental Specialists to use patient records for diagnosis, treatment, promotion, and education.

_____ I authorize Kingstowne Dental Specialists to release any information necessary for insurance purposes and authorize direct payment of insurance benefits to Dr. Marzban for services rendered.

_____ I understand the risks of unencrypted email and give my consent for Kingstowne Dental Specialists to use unencrypted email to communicate with me and my dentist regarding personal health information (appointment scheduling, billing & payment, orthodontic care & treatment, X-rays, and emergency questions).

PLEASE LIST ANY OTHER PARTIES 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: _____

Signature of Patient or Responsible Party _____ Date_____

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 the acknowledgement
- ☐ Other (Please Specify) _____

Staff Person Initials _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____ YES	_____ NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

IF SO, WHERE? _____