nova Children's Dentistry of ASHBURN
"smiles for a lifetime"

Date: _____

Patient Information

Child's Full Name: _____ Name called by: _____

Age: _____ Date of Birth: ___/___/___ Sex: ❑ M ❑ F Place of Birth: _____

Child's Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: (___) _____

Brothers (Names & Ages): _____

Sisters (Names & Ages): _____

Child's Physician: _____ Phone: (___) _____

Address: _____ Date of Last Exam: _____

Whom may we thank for referring your child to our office? _____

Parent/Guardian Information

Parent/Guardian Name: _____

Relationship to Patient: _____ Email Address: _____

Social Security Number: ___/___/___ Date of Birth: _____

Employer: _____ Cell Phone: (___) _____

Home Address (if different from above): _____

Parent/Guardian Name: _____

Relationship to Patient: _____ Email Address: _____

Social Security Number: ___/___/___ Date of Birth: _____

Employer: _____ Cell Phone: (___) _____

Home Address (if different from above): _____

Emergency Contact/Friend or Relative Not Living With You

Name: _____ Phone: (___) _____

Address: _____ Relationship to Patient: _____

Insurance Information

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's SSN /ID#: _____

Insured's Employer: _____

Name of Insurance Company: _____ Group Number: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform NOVA Children's Dentistry of Ashburn of any changes to the information I have provided. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

_____ _____

Signature of Insured Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to NOVA Children's Dentistry of Ashburn.

_____ _____

Signature of Insured Date

Please Continue on Next Page

Child's Name: _____

Child's Medical History

Please list any medications your child is currently taking: _____

Does your child have, or has he/she ever had, any of the following diseases, conditions or procedures?

- ☐ Cancer/Tumors
- ☐ Chemotherapy
- ☐ HIV + AIDS / ARC
- ☐ Abnormal Bleeding
- ☐ Anemia / Blood Disorders
- ☐ Bruises Easily
- ☐ Diabetes / Blood Sugar Problems
- ☐ Blood Transfusions
- ☐ High / Low Blood Pressure
- ☐ Tonsillitis
- ☐ Birth Defects
- ☐ Cleft Lip / Palate
- ☐ Autism Spectrum
- ☐ Speech, Learning, or Hearing Disabilities
- ☐ Developmental Delays
- ☐ Psychological or Emotional Problems
- ☐ Glandular or Hormonal Problems
- ☐ ADHD / ADD
- ☐ Kidney Bladder Problems
- ☐ Liver Problems, Jaundice or Hepatitis
- ☐ Convulsions, Seizures, Fainting or Epilepsy
- ☐ Rheumatic Fever / Rheumatic Heart Disease
- ☐ Congenital Heart Disease or Heart Murmur
- ☐ Arthritis or Rheumatism
- ☐ Tuberculosis or Pneumonia
- ☐ Jaw Problems: TMJ / TMD
- ☐ Asthma or Hay Fever
- ☐ Accidents or Severe Infections
- ☐ Any Recent or Pending Surgery/Recent Injuries
- ☐ Sensory Processing Disorder

If yes to any of the above please explain: _____

Are your child's immunizations current? ☐ Yes ☐ No If no please explain: _____

Name of Pharmacy: _____ Phone: ( ) _____

Is your child allergic to: ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Red Dyes ☐ Aspirin
☐ Sulfa Drugs ☐ Dental Anesthetics ☐ Other(s): _____

Does your child have any of the following mouth habits? ☐ Thumb Sucking ☐ Mouth Breathing
☐ Pacifier ☐ Nail Biting ☐ Finger Sucking ☐ Grinding/Clenching ☐ Other(s): _____

Dental History

Date of last dental visit: _____ By Dr. _____

Do you have any records (including x-rays) from another practice? _____

Has your child ever complained about any dental problems? _____

Does your child still take a bottle or sippy cup? _____

Does your child brush daily? ☐ Yes ☐ No How often? _____

Do you assist your child with brushing? ☐ Yes ☐ No How often? _____

Is dental floss used? _____

How does your child receive Fluoride?

☐ Water Supply ☐ Dentist ☐ Toothpaste ☐ Vitamins ☐ Tablets ☐ None ☐ Other: _____

Child's attitude towards Dentistry: _____

Reason for Today's Visit/Chief Concerns: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____
Signature of Insured Date

_____
Print Name

This Space For Internal Use

44121 Harry Byrd Highway, Suite 265, Ashburn, VA 20147
Phone 703-858-1550 • www.novachildrensdentistry.com

nova
Children's Dentistry
"smiles for a lifetime"

CONSENT FOR SERVICES

As a condition of your treatment by NOVA Children's Dentistry financial arrangements must be made in advance. NOVA Children's Dentistry depends upon reimbursement from its patients for the costs incurred in their care. Financial responsibility for each patient must be determined before treatment is initiated and completed.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are rendered. Cash, check, credit and debit cards are accepted (VISA, Mastercard and Discover)

Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that he/she is personally responsible for payment of all dental services. NOVA Children's Dentistry will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the Offices can and will not render services on the assumption that our charge s will be paid by an insurance company.

I understand that NOVA Children's Dentistry gives me a treatment plan based on my insurance company's estimates. This estimate is not a guaranteed payment; the insurance company is unable to provide the exact amount that will be paid until they receive the claim.

I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to paythe reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

CANCELLATIONS & MISSED APPOINTMENTS - Since appointment times are reserved exclusively for your child, we require that you notify our office 72 hours in advance of your scheduled time if you are unable to keep your appointment. A $50.00 fee will be accessed to your account for every broken appointment without at least 24 hour prior notice. Multiple cancellations without prior notice may result in dismissal from our practices.

I grant my permission to NOVA Children's Dentistry or Offices' assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Patient Name	Relationship to Patient
Signature of Patient, Parent or Guardian	Date

ASHBURN
44121 Harry Byrd Highway
Suite 265
Ashburn, VA 20147
Phone 703-858-1550

www.novachildrensdentistry.com

SOUTH RIDING
43130 Amberwood Plaza
Suite 230
South Riding, VA 20152
Phone 703-996-3520

nova
Children's Dentistry
"smiles for a lifetime"

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

NOVA Children's Dentistry

44121 Harry Byrd Highway
Suite 265
Ashburn, VA 20147
703-858-1550

43130 Amberwood Plaza
Suite 230
South Riding, VA 20152
703-996-3520

ACKNOWLEDGEMENT OF 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.

_____
(Please Print Name)

_____
(Signature)

_____
(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
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify) _____

Children's Dentistry
ASHBURN

Children's Dentistry and
Orthodontics
SOUTH RIDING

FINANCIAL POLICY

1. Charges for services rendered are due and payable on the day of the appointment.

2. NOVA Children's Dentistry of Ashburn and South Riding assist with filing insurance; however, the Patient, Parent, or Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company. **There are no exceptions.** When treatment co-pays are quoted by the office, these are estimates only, your actual insurance coverage may be less or more.

3. Personal checks that are returned due to insufficient funds are subject to a $30.00 service fee.

4. All accounts over 60 days are considered past due. Such accounts are subject to 18% APR or 1.5% monthly finance charges. Past due accounts may be referred to an authorized collection agency. Accounts sent to a collection agency will be assessed a $30.00 collection fee or 42% collection charge on the unpaid balance, whichever is greater. The Patient, Parent, or Guardian will also be liable for any applicable attorney fees and court costs. Accounts that have been referred to an outside collection agency will be placed on a CASH ONLY basis for any future treatment.

5. We are required by the State of Virginia to keep patient records for three years past the final date of treatment. Records of patients that have not been to this office in over three years may be purged. If you are moving or leaving the practice for any reason you may want to request a copy for your records. There will be a nominal charge to duplicate your x-rays and records.

6. Payment plans are available. Please talk to our office manager to set up a plan.

I have read and understand the Financial Policy of NOVA Children's Dentistry of Ashburn and South Riding. I agree to be responsible for all services and materials not paid by my dental insurance for me and my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to NOVA Children's Dentistry of Ashburn and South Riding, unless payable to me directly per the Insurance Plan.

Patient Name _____ Relationship to Patient _____

Signature of Patient, Parent or Guardian _____ Date _____

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Late and Cancellation Policy

We expect our patients to arrive 5 minutes early or on time for their appointments. Patients arriving 10 minutes after their reserved time slot begins may need to have their appointment rescheduled.

If you must reschedule your child's dental appointment, we require at least 24 hour's notice from the time of your appointment. If you are unable to give notice, we have the right to charge $50.00 per child or to limit the times of your future appointments between 10:00am and 2:30pm. Following a third cancellation or no call/no show we reserve the right to dismiss your family from our practice.

We have instituted this policy out of respect for our staff and our doctor's time. With less than 48 hours, these cancellations are more difficult to fill. Furthermore, this prevents someone else from being able to schedule into that time slot. Seeing as your appointment time is reserved exclusively for you, we do not double book appointments.

We understand that life can be unpredictable and sometimes things happen - sickness, family emergency, etc. Out of courtesy, we waive this fee for the first occurrence only.

By signing below, you acknowledge that you have read and understand our cancellation policy as described above.

Parent/Guardian Signature _____

Date _____