David M. Treff, DDS
5284 Lyngate Court •Burke, VA, 22015
703-712-8077 Office • 703-562-0812 Fax
www.PediatricDentistryofBurke.com

Child's Full Name: _____ Nickname: _____ Sex: M F

Date of Birth: ____/____/_____ Age: _____ Social Security #: _____/_____/_____

Home Phone (_____)_____ Address: _____Zip Code_____

Grade: _____ School: _____ City: _____

Name(s) and ages of other children in family: _____

Please list the child's hobbies / interests: _____

Whom may we thank for referring you? _____

Who is accompanying the child today? _____ Relation: _____

Who has legal custody of this child? _____

Parent/Legal Guardian Information: (please circle) Mother / Father Step Mother /Father Guardian

Parent's Marital Status: Married Divorced Separated Widowed Single (Please Circle)

Name: _____ Date of Birth: _____

Social Security #: _____ Email: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell / Pager / Other Phone _____
Employer: _____
Dental Insurance: Yes___ No___ **Medical Insurance Plan Name**: _____
ID #: _____ Group#_____

Parent/Legal Guardian Information: (please circle) Mother / Father Step Mother /Father Guardian

Parent's Marital Status: Married Divorced Separated Widowed Single (Please Circle)

Name: _____ Date of Birth: _____

Social Security #: _____ Email: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell / Pager / Other Phone _____
Employer: _____
Dental Insurance: Yes___ No___
Company_____

Emergency Contact

His / Her Name: _____ Relation:_____

Cell / Pager / Other Phone (_____)_____

Dental Insurance Information:

Dental Insurance Company:_____

Subscriber ID:_____ Group #: _____

Consent for Examination and Treatment:

I, the undersigned, have completed the above information to the best of my knowledge. Any information that I feel may not be complete will be discussed with the doctors and/or staff.

I authorize the doctors and their dental staff to perform an oral examination, a dental prophylaxis (cleaning), and, if appropriate, topical fluoride application. Dental radiographs (x-rays) may be taken as necessary (in accordance with the guidelines established by the American Dental Association) to complete the diagnosis of my child's oral condition. If dental treatment becomes necessary, I authorize the performance of necessary treatment, medication, and therapy that is indicated in connection with dental care of the above minor patient and authorize the doctors to choose and employ such techniques and assistance as deemed fit during the treatment. I understand that I will have the right to be provided with answers to questions, which may arise during the course of my child's diagnosis and treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it. Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment.

Name (Printed) _____Signature _____

Relationship _____Date_____

Notice of Privacy Practices Acknowledgement:

Incidental Disclosures: The Open Bay. We use an open bay in our office for most dental treatments (recall appointments and sealants). This type of environment is used for many reasons including positive behavior reinforcement (kids seeing other kids behaving well). Other patients or parents in the office may overhear parts of dental treatments and/or conversations. If you find that your child needs additional privacy, please request a closed door operatory. I have read and agree to the Notice of Privacy Practices given to me by Pediatric Dentistry of Burke, PC.

Signature: _____ Date: _____

Permission to Treat Without Parent/Guardian Accompanying Child:

Pediatric Dentistry of Burke must receive permission from a child's parent or legal guardian before providing treatment for any cleaning/trauma/restorative care that is non-life threatening. This form gives Pediatric Dentistry of Burke legal permission to treat your child in case you cannot accompany your child to the office for treatment. If this information is not on file with us or presented by the party accompanying your child (baby-sitter, relative, friend), Pediatric Dentistry of Burke will contact the child's parent or legal guardian before he or she is seen by the dentist. I give Consent by Proxy to:

Name (Printed) _____relationship to patient_____

Parent/Guardian Name:_____ Date: _____ Signature;_____

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Office, Dental Insurance Information and Financial Policies

Dear Patient:

Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family will feel welcome to our dental family.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. Please choose the option the works best for you.

♦**Dental Insurance-If you have dental insurance, as a service to you, we will complete your insurance form with all the necessary information and submit it to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.**

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

♦**If your insurance company has not made a payment within 30 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship).**

♦**Payment is due at the time treatment is rendered. We accept Cash, Personal checks, Master Card and Visa charge or debit cards.**

♦**Monthly payments- If you need to make long-term payments we can offer financing with Care Credit. You must qualify to use this option. Or we can offer a two-month payment plan with a credit card on file.**

All patients with an outstanding balance will receive a statement each month. There is a finance charge of 1.5 % (18% APR) on all accounts 60 days overdue. If you have a returned check you will be charged a return check fee of $50.00 per check.

We reserve the right to charge for appointments broken with out proper 48 hours notice. The length of the appointment scheduled will determine a charge for the broken appointment. There is a minimum charge of $35.00 for a broken appointment cancelled with less than 48 hours notice.

SIGNIFICANT EXPOSURE- Section 32.1-45,1(A) and (B), Code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and /or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

Minor Patients- The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, a MC/VISA and or check, cash payment is paid on the account at the time of service.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges incurred to collect this account) on the principal balance of 18% (eighteen) per annum from the date of service. In the event the account is turned over to collections you will need to discuss all payment arrangements with our attorney **Charles Anderson, Attorney at Law, 11860 Sunrise Valley Drive, Suite 100, Reston, VA 20191.**

_____ _____

Signature of patient, parent or guardian **Date**