Children's Dentistry & Orthodontics *of Lynchburg*

Patient Information Form

Patient Name: _____ Date of Birth: _____
FIRST MI LAST

Preferred Name: _____ Gender: Male Female

Favorite interest, sport, toy, pet or color: _____

Parent/Legal Guardian Name(s): _____ _____

Street: _____ City: _____ State: _____ ZIP: _____

Mailing Address (if different from above): _____

Home Phone: _____ School: _____

Name of Person Bringing Patient to Appointment: _____

How are you related to this patient? _____ Do you have legal custody of this patient? Yes No

Cell Phone: _____ Work Phone: _____ Email: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Mother's Employer: _____ Father's Employer: _____

With whom does the patient live? _____

Name of Emergency Contact (other than parent): _____

Relationship to Patient: _____ Phone: _____

Do you have Dental Insurance? Yes No

Name of Insurance Company: _____

Full Name of Policy Holder: _____ Date of Birth: _____

Address of Policy Holder (if different from patient): _____

Policy Holder's Social Security #: _____-_____-_____ Employer: _____

Patient's/Parent's Chief Concern? _____

Whom may we thank for referring you? _____ Date of Last Dental Visit: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? ☐ Parent/Friend _____ ☐ Search Engine ☐ Facebook ☐ _____

I will not hold Children's Dentistry & Orthodontics of Lynchburg or any member of their staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes later to the content on this form, I will so inform this practice.

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

CELL PHONES & CAMERAS MAY NOT BE USED IN THE CLINICAL AREA

Children's Dentistry & Orthodontics *of Lynchburg*

Medical History

Patient Name: _____ Date of Birth: _____

Is your child under a physician's care now?	☐ Yes	☐ No	If yes, explain: _____
Has your child ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, explain: _____
Has your child ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, explain: _____
Is your child taking any medications, or drugs?	☐ Yes	☐ No	If yes, explain: _____
Does your child take, or has taken, Phen-fen or Redux?	☐ Yes	☐ No	If yes, explain: _____
Has your child ever taken Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes, explain: _____
Is your child on a special diet?	☐ Yes	☐ No	If yes, explain: _____
Does your child use controlled substances?	☐ Yes	☐ No	

Girls:
Pregnant? ☐ Yes ☐ No Taking Oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Is your child allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If other, please explain:_____

Check if your child has, or has had, any of the following:

☐ AIDS/HIV Positive	☐ Congenital Heart Disorder	☐ Heart Trouble/Disease	☐ Psychiatric Care
☐ ADD/ADHD	☐ Convulsions	☐ Hepatitis A	☐ Radiation Treatments
☐ Anaphylaxis	☐ Cortisone Medicine	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ Anemia	☐ Diabetes	☐ Herpes	☐ Renal Dialysis
☐ Angina	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis/Gout	☐ Easily Winded	☐ High Cholesterol	☐ Rheumatism
☐ Artificial Heart Valve	☐ Emphysema	☐ Hives or Rash	☐ Scarlet Fever
☐ Artificial Joint	☐ Epilepsy or Seizures	☐ Hypoglycemia	☐ Shingles
☐ Asthma	☐ Excessive Bleeding	☐ Irregular Heartbeat	☐ Sickle Cell Anemia
☐ Asperger's Syndrome	☐ Excessive Thirst	☐ Kidney Problems	☐ Sinus Trouble
☐ Autism	☐ Fainting Spells/Dizziness	☐ Learning Disability	☐ Spina Bifida
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problem	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Glaucoma	☐ Lung Disease	☐ Tonsillitis
☐ Cancer	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tumors or Growths
☐ Chest Pains	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Ulcers
☐ Cold Sores/ Fever Blisters	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Yellow Jaundice

Has your child ever had a serious illness not listed above? ☐ Yes ☐ No If yes, explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Children's Dentistry and Orthodontics of Lynchburg of any changes in medical status.

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

Children's Dentistry & Orthodontics *of Lynchburg*

Consent for Disclosure of Protected Health Information (HIPAA)

SECTION A: Patient/ Parent/ Legal Guardian Giving Consent

Patient Name: _____ Date of Birth: _____

SECTION B: Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information or my child's protected health information as described in the "Notice of Privacy Practices."

Signature: _____ **Date:** _____

Relationship to Patient: _____

Other person(s) to whom you give permission to discuss health information or bring child to routine care appointments:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Children's Dentistry & Orthodontics *of Lynchburg*

Consent to Accompany a Minor Child

Patient(s) Name: _____ Date(s) of Birth: _____

_____ _____

_____ _____

_____ _____

Authorized Person(s): _____ Relationship: _____

_____ _____

_____ _____

_____ _____

I, _____, give permission to the above authorized person(s) to accompany my child to
(Parent or Legal Guardian)

Children's Dentistry & Orthodontics of Lynchburg for dental appointments. I also give permission to the person named above to make any necessary decisions regarding dental treatment for my child, including but not limited to:

- the consent for this authorized person to sign any and all forms required to give permission to **Children's Dentistry & Orthodontics of Lynchburg** to treat the dental needs of my child on the day of service and to discuss and sign any forms pertaining to the future dental treatment needs (ie: treatment plans) of my child

- the consent to the dental practice to discuss finances (treatment charges, account balances, next visit charges) with this authorized person and for this person to schedule any future dental visits for my child

I understand this consent will be valid for one year or until I rescind this agreement in writing.

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

Children's Dentistry & Orthodontics *of Lynchburg*

Patient Name: _____ Date of Birth: _____

We welcome your child and family into our practice and are committed to providing your child(ren) with quality, compassionate and professional care. The following polices have been established to facilitate a clear and professional relationship between you and our office.

Appointment Agreement
48-HOUR NOTICE is required if you need to reschedule an appointment. If you cancel or reschedule **LESS THAN 24 hours** prior to a sedation, a hospital visit or on two separate occasions for other appointment types, **we will not reschedule your child(ren) for additional appointments**. Missed appointments and/or untimely scheduling will cause your child to be inactivated as a patient in this practice. **Inactivated patients will not be reactivated.**

It is your responsibility to let us know of any changes in your contact information, including address, phone numbers, emergency contacts, etc. **If your phone number changes and we are not able to reach you to reconfirm an appointment, YOUR APPOINTMENT WILL BE CONSIDERED CANCELLED**.

A parent or legal guardian must accompany your child to a restorative appointment (anything that requires the use of analgesia/medication). Adults over 18 who are listed on the HIPAA form may accompany your child to a hygiene (cleaning & exam) visit.

Financial Agreement
Dental insurance is a contract between you, and/or your employer and your insurance company. We are not a party to that contract. Our recommendations for treatment are based on what will be best for your child and not what your insurance may or may not pay. If you have any concerns about your coverage, please contact your employer or your insurance company. You must present insurance card upon every visit to our office. If you do not have your card, you will be asked to sign a waiver and may be required to pay in full at the time of service.

Though we are not obligated to do so, we will file your primary insurance claim as a courtesy to you. Any amount estimated not to be covered by your insurance company is payable at the time services are rendered. Please remember this is only an ESTIMATE and not a guarantee of what your insurance will pay. You may owe more once the claim has been paid by your insurance.

We allow a maximum of 45 days for insurance reimbursement. After this period, **any unpaid amount is due in full, by you, within 30 days**. It is your responsibility to let us know of any changes in your insurance information. If we do not have correct or updated information for filing at the time of service, we will not be responsible for unpaid claims.

Some insurance carriers will only send reimbursement to you, not to our office. In this case, it is your responsibility to notify us immediately if your insurance company has sent our payment to you. We reserve the right to require payment in full on day of service if we find that the insurance company repeatedly sends our reimbursement to you.

There will be a **$25.00 returned check fee** for all personal checks returned for insufficient funds.

After attempts to collect outstanding funds and a 60-day grace period from time of service, parents/guardians not fulfilling their financial obligation will be sent to collections. Overdue accounts greater than sixty days will be subject to all collections charges, interest fees (compounded monthly at 6%), legal fees, and any court costs associated with recovering funds due.

General Agreement
If an employee of the practice is accidentally contaminated with your child's body fluids (blood, saliva, vomit, mucus, etc.) your signature on this form gives permission for us to get your child's blood drawn for infectious disease status, as defined by Virginia law and authorizes the testing facility to release the test results to the injured employee.

I have read and understand these policies and will comply with all items. I am also responsible for all account balances.

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

Children's Dentistry & Orthodontics *of Lynchburg*

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This notice takes effect 11-17-2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations, for example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Unless you give us additional written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications to third parties without your written authorization.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

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

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcard, or letters).

PATIENT RIGHTS

Access: You have the right to review or receive copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 17, 2008. If you request this accounting more than once in a 12-month period, we may charge you a responsible, cost -based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information: Office Manager, Children's Dentistry and Orthodontics of Lynchburg
105 Paulette Circle, Lynchburg, VA 24502 Tel. (434) 237-0125

Children's Dentistry & Orthodontics *of Lynchburg*

Meet Our Doctors

Dr. Shepherd Sittason received his D.D.S. from The Ohio State University College of Dentistry in 1998. He then joined the U.S. Navy and served for two overseas tours, during which he earned his AEGD (Advanced Education in General Dentistry). Helping and working with military families strengthened his interest in pediatric dentistry and in 2004, he separated from the Navy in order to pursue his career as a specialist. He returned to school to earn his Certificate of Pediatric Dentistry from the University of Texas Health Science Center San Antonio in 2007 and became board certified in 2012. Though he's lived in many places, he feels he couldn't have chosen a better place than Lynchburg to settle and raise his two children together with his wife, Jennifer.

Dr. Keith Pyle received his D.D.S. from the Medical College of Virginia in 1997. He completed a one-year AEGD (Advanced Education in General Dentistry) in 1998 with the Bureau of Naval Medicine. Dr. Pyle practiced general dentistry for four years in the U.S. Navy and four years as an associate in private practice in Lynchburg and Virginia Beach. In 2006, he returned to school and in 2008 earned his Orthodontic Specialty Certificate from The University of Nevada, Las Vegas. He enjoys spending time with his wife and two children.

Dr. Preston Stewart attended Loma Linda University School of Dentistry where he discovered the joy of working with children. In 2016, he graduated with honors in Pediatric Dentistry. Afterward, he received his Certificate of Pediatric Dentistry from NYU Langone Health on Maryland's Eastern Shore. As a pediatric dentist, Dr. Stewart loves educating children and helping them navigate the dental experience. Originally from Salt Lake City, Utah, he is excited to return to the mountains as he enjoys hiking, camping, and kayaking. He and his wife, Rebecca, look forward to making Lynchburg their home and raising their family.