A. Scott Anderson, III, DDS
Ryan R. Reopelle, DDS

Parkway
PEDIATRIC DENTISTRY

3650 Colonial Ave. SW
Roanoke, VA 24018
(p) 540-989-3639
(f) 540-989-4749

Office Policies

Patient's Name _____ Birthdate _____

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our practice policies is important to our relationship.

Appointments
We ask for your utmost courtesy regarding your scheduled appointments as we exclusively reserve time to care for your child. Please notify us 48 hours prior to your appointment time if you must cancel or reschedule. We understand that unforeseen business and personal emergencies do occur; however, repeated last minute cancellations and broken appointments will incur a charge of $50.00. Most insurance companies will not reimburse the cost of a missed appointment.

Fees and Payment Policies
Payment for professional services is due at the time dental treatment is provided. If you have insurance, then your co-payment is due as service is rendered. If an account shows an overdue balance, future treatment may be delayed until the balance is cleared. The accompanying adult and/or parent is responsible for payment at the time of the appointment. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express.

About Insurance
We will file your insurance claim as a courtesy and will accept estimates of benefit payments from your insurance company. Your portion of co-payment is due at the time of service. Please keep in mind that **this is only an estimate of what your insurance will cover for you**. If there is any difference after your insurance pays, we will contact you to make the necessary adjustments.

It is important to understand that your insurance is a contract between you, your employer, and the insurance company, not our office. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We cannot be responsible for accuracy of any insurance information. It is your responsibility to be familiar and understand your insurance policy and terms. It is your responsibility to notify us in any changes in your insurance policy. **You are responsible for payment not paid by your insurance company**.

I am (we are), and will continue to be until further written notice, responsible for payment for the charges for the professional services rendered for this child. In the event the account becomes delinquent (90 days and over), a finance charge of 18% (1.5% per month) will be added to the account. In the event the account is turned over to a collections attorney, I agree to be responsible for an attorney fee equal to 33.333% of the outstanding balance due on the date the account is turned over for collection. In the event the account becomes delinquent and it becomes necessary to expend costs for the collection of the account, I understand that I will be responsible for the costs. These costs could include court costs for filing suit against me.

_____ (***initial)*** I request the privilege of assigning my child's dental insurance benefits to the office of Dr. Anderson and Dr. Reopelle in lieu of paying for all the services at the time they are provided for my child. If there is an outstanding balance remaining on my child's account with Parkway Pediatric Dentistry, immediately upon receipt, I agree to submit any and all payments received from any and all insurance companies to the office of Dr. Anderson and Dr Reopelle along with any and all accompanying explanations of benefits (EOBs). I understand that if I fail to do so, a penalty in the amount of 25% of the outstanding balance will be added to my child's account along with the previously agreed upon 1.5% monthly service charge.

I have read the above conditions and agree to their content. I give my permission for my child to be examined and treated now and such times when I bring or send him or her to this office for dental care.

Signature of Parent/Guardian _____ Date _____

Printed Name _____ Relationship to Patient _____

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Consent for Disclosure of Protected Health Information (HIPAA)

Patient's Name _____ Birthdate _____

I understand that my child has rights to privacy regarding his or her protected health information. These rights are provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which went into effect on April 14, 2003. I understand that by signing this consent I authorize **Parkway Pediatric Dentistry,** Dr. Anderson, Dr. Reopelle and their staff to use and disclose **my child's** protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in this treatment);
- Obtaining payment from third party payers (e.g. your insurance company);
- The day-to-day healthcare operations of the practice.

I have been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my child's protected health information, and my child's rights under HIPAA. I understand that **Parkway Pediatric Dentistry** and Drs. Anderson and Reopelle reserve the right to change the terms of this notice from time to time and that I may contact this office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions of how my child's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Parkway Pediatric Dentistry and Drs. Anderson and Reopelle are not required to agree to these requests. However, if the restrictions are agreed to then they must be complied with.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

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

Signature of Parent/Guardian _____ 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 _____

Parkway Pediatric Dentistry Medical History

Child's name: _____ Nickname: _____
Date of birth: _____ Phone number: _____
Home address: _____
Street City State Zip code
Father's name: _____ Employment: _____
Father: _____
Date of birth dd/mm/yyyy Home Phone # Work Phone # Cell phone # (May we text?) email
Mother's name: _____ Employment: _____
Mother: _____
Date of birth dd/mm/yyyy Home Phone # Work Phone # Cell phone # (May we text?) email
Person(s) responsible for bill: _____
Address: _____ Phone: _____
Street City State Zip code
Child's primary dental insurance coverage: _____
Insurance Information: ID# _____ Group # _____
Child's secondary dental insurance coverage: _____
Insurance Information: ID# _____ Group # _____
Child SSN: _____ Mother SSN: _____ Father SSN: _____
Child's physician(s): _____ Phone: _____
Is your child receiving treatment by a physician? _____
If yes, for what is he/she being treated?_____
Is your child now taking medications? _____ Reason: _____
Prescription medications: _____ Non-prescription medications: _____
Has your child had any of the following? _____ Please check all that apply.

☐ Rheumatic fever	☐ Liver disease	☐ Latex Allergy
☐ Autism	☐ Hepatitis	☐ Red Dye Allergy
☐ Heart disease	☐ Diabetes	☐ Musculo-Skeletal Disorder(s)
☐ Heart murmur	☐ Seizure(s)	☐ Developmental Disorder(s)
☐ Respiratory disorders	☐ Emotional disorder(s)	☐ ADD/ADHD
☐ Tuberculosis	☐ Bleeding problems	☐ Speech disorder(s)
☐ Asthma	☐ Anemia	☐ Other _____

Are your child's immunizations up to date? ☐ yes ☐ no
Have you been told antibiotics are recommended for your child's dental appointments? ☐ yes ☐ no
Other healthcare concerns or other information: _____
_____
_____
Is your child allergic to any anesthetics? _____
Any other allergies? _____ Medicine or drug allergies? _____
Has your child taken penicillin? _____ Unfavorable reaction? _____
Has your child been hospitalized overnight? _____
If yes, when and why? _____
Has your child been put to sleep with a general anesthetic? _____
Were there any complications? _____
Were there any complications during pregnancy, delivery, or the first year of life? _____
If yes, please describe: _____
_____
_____
Names and ages of brothers and sisters: _____
_____
Pets: _____ Hobbies: _____
Interests: _____
Comments: _____

Yes No

☐ ☐ Do you know if your water supply is fluoridated? Concentration: _____

☐ ☐ Has your child had fluoride supplements prescribed? By whom: _____

☐ ☐ Has your child had fluoride treatment in school?

☐ ☐ Has you child had fluoride treatment in a dental office?

☐ ☐ Have dental x-rays been made of your child's teeth?

If yes, approximate date of the most recent ones:

Bitewings: _____

Panoramic: _____

Are current legible copies available for our use today? _____

Comments: _____

_____

Is this your child's first visit to a dentist? _____

If not, who was your child's former dentist(s)? _____

How did you learn of this office (who referred you)? _____

Reason for referral: _____

Comments: _____

If this is not the first visit, how were previous visits tolerated by your child? _____

_____

How do you think he/she will react in the dental environment? _____

_____

How would you describe your child's temperament? _____

_____

Is there now, or has there ever been, any of the following?

☐ Cavities ☐ Toothache ☐ Dental pain ☐ Broken teeth ☐ Traumatized teeth

Is there now, or has there ever been, any of the following?

☐ Breaths through the mouth ☐ Suck thumb(s) and / or fingers(s) ☐ Pacifier use

☐ Bites fingernails ☐ Bites or sucks lips ☐ Blanket use with oral habit

☐ Tongue habits ☐ Other habits affecting mouth or teeth

How often and when does your child brush his/her teeth? _____

How often do his/her teeth get flossed? _____

Does he/she brush alone or with assistance? _____

Do you have any particular concerns about your child's dental health you would like addressed by the dentist or staff? _____

_____

_____

Insurance coverage is an agreement between the insurance company and my family. As a courtesy to families, this office will complete insurance claim forms at every visit which will promptly be submitted or provided for my use. Balances not paid by insurance coverage are due when the professional services are rendered.

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Printed Name: _____Signed: _____ Date: _____

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