

WELCOME TO DR. SHOHREH SHARIF'S OFFICE

PATIENT INFORMATION

Last Name:		First Name:		M.I.:
DOB:	Age:	Nickname:	Male ___ Female ___	
School:			Grade:	

MEDICAL ALERTS <small>Please indicate Y/N for each</small>	MEDICAL INFORMATION
Y N Heart Murmur	Describe the overall health of the child: Good ___ Fair ___ Poor ___ List medications child is currently taking: _____ _____ List allergies to medication: _____ _____ Describe any operations: _____ _____ Describe any hospitalization(s): _____ _____ Physicians Name: _____ Phone (_____) _____ - _____ City: _____
Y N Cancer	
Y N Diabetes	
Y N Rheumatic Fever	
Y N HIV+/Aids	
Y N Hemophilia	
Y N Asthma	
Y N Hepatitis	
Y N Tuberculosis	
Y N Prosthesis	
Y N Abnormal Bleeding	
Y N Hearing Impairment	
Y N Congenital Heart Dis.	
Y N Convulsions/Epilepsy	
Y N Kidney/Liver Problems	
Y N History of Scarlet Fever	
Y N Handicap/Disability	
Y N Environmental Allergies	
Y N Allergies to Medication	
Other:	DENTAL INFORMATION
	Y N Does the child brush daily? If not, how often?
	Y N Does the child floss daily? If not, how often?
	Y N Is the water that the child drink fluoridated?
	Y N Does the child take fluoridated supplements?
HABITS	Y N Has the child ever had pain/tenderness in the jaw joint? (TMJ)
Y N Thumb/Finger Sucking	PARENTAL CONSENT
Y N Lip Sucking/Biting	I confirm that the information that I have given is true and correct. I understand that it is my responsibility to inform this office of any changes in my child(s) medical status, dental insurance, address, and/or phone number change. I also authorize Dr. Sharif and her dental staff to perform the necessary dental services that my child may need. Parent/Guardian Sign: _____ Date: _____
Y N Nursing/Bottle Habits	
Y N Pacifier Habit	
Y N Nail Biting	
Other:	

DOCTOR NOTES

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian. Initial: _____ Date: _____
Medical History Update: _____ Initial: _____ Date: _____

PARENT/GUARDIAN INFORMATION

Name of Mother:	Today's Date:
Name of Father:	
Name of Legal Guardian:	
Parent(s) Marital Status: Married _____ Divorced _____ Single _____ Other _____	
Who does the child live with: Mother _____ Father _____ Other _____	
Who is accompanying the child today: Mother _____ Father _____ Other _____	
Whom should we contact about appointments: Mother _____ Father _____ Other _____	
Contact #: ()	Best time to call:
Who may we thank for referring you? Yellow Pages _____ Mailer/Coupon _____ Insurance _____ Walkby/Walkin _____ Dr. _____ Patient's Parent _____ Other (Please specify) _____	

FINANCIAL RESPONSIBLE PARTY

(Information of Parent/Guardian who is present and signing these documents)

Last Name:	First Name	M.I.
DOB:	SS#:	Employer:
Home Street Address:		
City:	State:	Zip Code:
Home #: ()	Work #: ()	x. Cell#: ()
Email Address:		
Disclaimer: Payment is due in full at the time services are rendered. Cash, check, and/or Visa/MasterCard accepted. The responsible party is ultimately responsible for any and all fees incurred. If dental insurance is filed, the estimated co-pay is due at the time services are rendered. The responsible party is further responsible for any amount discounted or disallowed by the insurance company, except in the case where the amount is a contractual discount. If the insurance does not remit payment within 60 days, the full balance becomes the obligation of the responsible party, and it is then the responsible party's burden to collect from the insurance carrier. If an account should ever require collections action, the responsible party will be obligated to pay any and all collection fees. <i>*I understand and accept the above disclaimer as the responsible party.</i>		
Today's Date: ____/____/____		
Name(Print) _____		Signature: _____

DENTAL INSURANCE INFORMATION

Insurance Name:	Phone: ()	
Claims Address:		
City:	State:	Zip Code:
Policy Holder:	Relation to Patient:	
I.D.#:	Group#:	DOB:
Patient Acknowledgement/Acceptance: I agree to pay according to the conditions and limitations of the policy at the times services are rendered. The signature below also constitutes my agreement as the insured or on behalf of the insured that the insurance company shall submit payment to Dr. Sharif. In the event that the insurance company incorrectly sends the check to me, I will be responsible to either sign over the check to Dr. Sharif or directly pay the balance immediately.		
Parent/Guardian Signature _____		Date: ____/____/____

NOTICE OF PRIVACY PRACTICES

Shohreh Sharif, DDS
Pediatric and Adolescent Dentistry
3700 Joseph Siewick Drive, Ste 104
Fairfax, Virginia 22033

This notice describes how health information about your child or legal ward 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 child's health information. We are also required to give you this Notice about our privacy practices. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (4/14/2003), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time.

Uses and Disclosures of Health Information

We use and disclose health information about your child's treatment, payment, and healthcare operations. For example:

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

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

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

Your Authorization: In addition to our use of your child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's 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, personal representative, or another person responsible for your child's care. If you are present, then prior to use or disclosure of your child's 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 based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's 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 child's health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your child's 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 of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of 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 messages, postcards, letters, and/or emails).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do. (You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies, postage, and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

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 six years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right 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.

Identification of Patients: We will require you to provide appropriate identification, such as photos for electronic chart recognition, drivers license, insurance cards appropriate for care and to perform the function of filing claims to appropriate payers.

I _____, have received a copy of this office's Notice of Privacy Practices.
Print Parent/Guardian Name

Please Print Patient Name: _____

Signature of Parent/Guardian: _____ **Today's Date:** _____

OFFICE POLICIES

We make every effort to honor your appointment time. However, as a pediatric dental practice emergencies are inevitable. Therefore, maintaining a strict schedule is not always possible. Patients are called back according to the type of procedure they are scheduled for, and not first come first served.

It is the **parent/guardian's** responsibility to be aware of all insurance maximums, deductibles, coinsurance, and services covered. It is recommended by the American Academy of Pediatric Dentistry to have fluoride treatment twice a year. However, if the insurance does not cover it, it is the parent/guardians responsibility to notify us not to give treatment. Once treatment is rendered, payment is due. **Children covered under Cigna HMO Insurance will need their parent/guardian to contact their insurance company regarding the age limitations for a pediatric specialist.**

Every patient is given a treatment plan if any restorative procedures are recommended. The treatment plans are only **estimated** fees. Exact amounts and balances are unknown until treatment is complete and claim is processed and received. **The parent/guardian is responsible for their co-pay portion on the day services are rendered.** For all hospital cases, please refer to your hospital instructions sheet.

Children age six and under are only seen in the morning during the hours of 9:00a.m. and 11:30a.m. If your child is scheduled for a procedure in our office and he/she is not cooperative for treatment, there will be an office visit fee of \$53.00 regardless of any service rendered.

To avoid additional fees, a 24-hour (business day) notice (from the time of your child's appointment) is required for any rescheduling or canceling of an office appointment. **A 72 hour (business day) notice (from the time of your child's appointment) is required for rescheduling or canceling appointments made on student/regular holidays, for families of two or more children, and for appointments made for an hour or more.** You may be asked to reschedule your child's appointment if you arrive 10 minutes or later. For all hospital cases, please refer to your hospital instructions sheet.

Disclaimer: Payment is due in full at the time services are rendered. **Cash, check, and Visa/MasterCard are accepted.** The parent/guardian is ultimately responsible for any and all fees incurred. If dental insurance is filed, the estimated co-pay portion is due in full at the time services are rendered. **A processing fee of \$5.00 is applied to your estimated co-pay if you are unable to pay at the time of the appointment.** The parent/guardian is further responsible for any amount discounted or disallowed by the insurance plan, except in the case where the amount is a contractual discount. If the insurance does not remit payment within 60 days, the full balance becomes the obligation of the parent/guardian, and it is then their burden to collect from the insurance carrier. **Accounts 30 days overdue are subject to a monthly late fee.** If an account should ever require collection action, the parent/guardian will be obligated to pay any and all collection fees.

Chaperone Consent: A chaperone consent slip is required for children accompanied to their appointment by someone other than their parent or legal guardian. This form authorizes the chaperone to consent to and render services for any recommended treatment without the presence of the parent/guardian. The chaperone must be prepared to take care of any and all co-pays due at the time of the appointment.

Parental Consent: I understand the information that I have given is true and correct to the best of my knowledge. It will be my responsibility to notify the office of any changes in my child's medical status, dental insurance, and address or phone numbers. I also authorize the Doctor and Staff to perform the necessary dental services that my child may need.

Patient Name: _____ **DOB:** ____/____/____

Parent/Guardian Signature: _____ **Date:** ____/____/____