Drs. Wood, Lombardozzi & Dunlevy
PEDIATRIC DENTISTRY & ORTHODONTICS

ACQUAINTANCE AND HISTORY QUESTIONNAIRE

Please present this questionnaire at the consultation appointment.

PATIENT

Patient's Name _____ Nickname _____

Today's Date _____ Birthdate _____ Sex _____ Age _____

Address _____ Zip _____ Phone _____

School _____ Grade _____ Interest _____

What is the child's attitude toward 1. School _____ 3. Dentistry _____

2. Brushing _____ 4. Orthodontics _____

Would you say the patient would cooperate fully in orthodontic treatment? _____

Has the patient been growing rapidly recently? _____ Is the patient a good, average, or fair student? (circle)

PARENTS

Father's Name _____

Address _____

Home Phone Number _____

S.S. Number _____

Occupation _____ How Long? _____

Place of Business _____

Business Phone _____

Mother's Name _____

Address _____

Home Phone Number _____

S.S. Number _____

Occupation _____ How Long? _____

Place of Business _____

Business Phone _____

Parents marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Who has custody of the child? _____ Number of children in family _____

Do other family members need orthodontic care? _____ Is the patient an adopted child? _____

ADULT PATIENT

Occupation _____ Place of Business _____

Business Phone _____ How long employed there? _____

Spouse's Name _____ Occupation _____ How long employed there? _____

Place of Business _____ Business Phone _____

S.S. Number _____

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MEDICAL HISTORY

Name and address of patient's physician _____

Present health: Good, Fair, Poor (circle) Date of last physical _____

Is patient now receiving medication? _____ If yes, for what? _____

Does the patient now have or has the patient had any of the following? (Check yes or no)

YES	NO		YES	NO		YES	NO	
_____	_____	Rheumatic Fever	_____	_____	Diabetes	_____	_____	Speech Problems
_____	_____	Heart Disease	_____	_____	Emotional Problems	_____	_____	Hearing Problems
_____	_____	Bleeding Problems	_____	_____	Mental Retardation	_____	_____	Tonsils Removed
_____	_____	Hepatitis	_____	_____	Drug Allergies	_____	_____	Sinusitis
_____	_____	A.I.D.S.	_____	_____	Frequent Colds	_____	_____	T.B.

4. Allergies _____ _____ If yes, list _____

5. Is your child taking any medication at this time? _____ _____ If yes, list _____

6. Is your child taking any Vitamins at this time? _____ _____ If yes, list _____

7. Has your child had any unfavorable reaction or allergy to medication, such as penicillin, aspirin or local anesthetic? _____ _____ If yes, list _____

8. Has your child ever been hospitalized? _____ _____ If yes, list _____

9. Date of last physical? _____

DENTAL HISTORY

Name and address of patient's general dentist _____

Has patient ever had a habit of sucking finger, thumb, or other? _____

How severe? _____ How long? _____ When? (nights only, etc.) _____

Has patient had previous orthodontic care? _____ If so, when? _____

For how long? _____ Treated by whom? _____

When did patient last see the dentist? _____ For what reason? _____

GENERAL INFORMATION

Who may we thank for referring you to this office? _____

What do you think is your/your child's biggest orthodontic problem? _____

Will payments be made by self, father, mother, or other? _____ Do you have dental insurance? _____

In separation or divorce situations, the individual who initiates services with us is held financially responsible.

Who do we contact in case of emergency? _____

CONSENT: Your child is a minor. Therefore, it is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary orthodontic treatment can be started. Authorization is also necessary to release medical information to my physician if needed. Authorization is hereby granted as such.

I hereby certify that the information I have given is correct and true to the best of my knowledge. Furthermore, I give permission for the release of all information to any/all physicians, institutions or to any agency which may have an interest in the settlement of payments for services rendered. I further authorize direct payment to H.A. JACK DUNLEVY, D.M.D., M.S., I agree to pay my account as it comes due and further agree that if I do not, I will pay all the expenses incurred in collecting the same, including court costs and a 33.3% attorney's fee.

I agree that a service charge of 1 1/2% per month or (18% per annum) will be added to account over 60 days delinquent.

I agree to provide H.A. JACK DUNLEVY, D.M.D., M.S. with address and other information changes so that his office can properly send current bills to me.

Signed _____

H. A. JACK DUNLEVY, D.M.D., M.S.
11601 ROBIOUS ROAD, SUITE 130
MIDLOTHIAN, VIRGINIA 23113
OFFICE (804) 378-7681
FAX (804) 378-6004

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

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

I have also been informed of and given the right to review and secure a copy of your ***Notice of Privacy Practices,*** which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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.

Signed this _____ day of _____, 20_____

Print Patient Name:_____

Parent/Guardian and Relationship to Patient:

_____

Please note: it is helpful to list below any family members or persons that could be accompanying the patient to appointments. Also, if there is SPECIFIC information you DO NOT want disclosed, such as financial information to anyone listed below, please notify our office HIPAA COMPLIANCE COORDINATOR, who can make additional notations of this.

☐ I,_____, hereby authorize the following person/persons may receive health treatment and financial information regarding the above named patient. Please note: it is helpful to list below any family members or persons that could be accompanying the patient to appointments.

Name/Relationship to Patient_____

Name/Relationship to Patient_____

Name/Relationship to Patient_____

☐ **NO, DO NOT DISCLOSE ANY TREATMENT INFORMATION** (please initial here)_____

Signature:_____