Patient Name: _____ Gender: ☐ Male ☐ Female

Medical History

General Health Review: Please review your child's past and present medical history.

Mark ***only*** if your child has the condition now, or has been treated for it in the past.

Allergy: ☐ Latex ☐ Drug ☐ Food ☐ Seasonal ☐ Other_____

Explain/List Others_____

☐ ADHD	☐ COLD SORES	☐ KIDNEY DISEASE
☐ ANEMIA	☐ DIABETES	☐ LIVER DISEASE
☐ ASTHMA	☐ EPILEPSY	☐ MENTAL DELAYS
☐ AUSTISM	☐ HEARING PROBLEMS/DEAF	☐ PHYSICAL DELAYS
☐ ASPERGER SYNDROME	☐ HEART DISEASE	☐ RESPIRATORY ISSUES
☐ BLOOD DISORDER	☐ DOWNS SYNDROME	☐ RECURRING HEADACHES
☐ CANCER	☐ HIV/AIDS	☐ SOCIAL DISORDER
☐ CEREBRAL PALSY	☐ HEART MURMUR	☐ VISION IMPAIRED/BLIND
☐ CLEFT LIP	☐ HEPATITIS	☐ OTHER_____

Does your child require Cardiac Pre-Medication before dental appointments? ☐ Yes ☐ No _____

Has your child ever been hospitalized? ☐Yes ☐No_____

Does your child take any medications? ☐Yes ☐No_____

If yes, please list: _____

TELL US ABOUT YOUR CHILD

Today's Date: _____

Patient's Last Name: _____ First Name: _____ Middle Int: _____

DOB: _____ Age: _____ Gender: Male ☐ Female ☐

Mailing Address: _____

Physical Address (if different): _____

Primary Phone Number: _____ Work #_____

Email Address_____

Child is: ☐ Biological ☐Adopted ☐ Foster ☐ other, please explain_____

Parents/Legal Guardian Information

Who is financially responsible for the account: _____SSN:_____ DOB_____

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

Custody Situation: ☐ Sole Custody ☐ Joint Custody

*****If someone does not have legal rights to the patient named above, a copy of the custody order must be obtained for verification. Otherwise, single or divorced parents are assumed to have joint custody*****

Primary Dental Insurance:

Relationship to Patient: ☐Mother ☐ Father ☐Self (Medicaid) ☐Other_____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Ins Address: _____Ins Phone # _____

Employer: _____ Insurance Company Name: _____

Secondary Dental Insurance:

Relationship to Patient: ☐Mother ☐ Father ☐Self (Medicaid) ☐Other_____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Ins Address: _____ Ins Phone # _____

Employer: _____ Insurance Company Name: _____

Brian T. Brumbaugh, D.D.S.
"Ride the Cavity Free Express"

FINANCIAL POLICY:
Thank you for choosing Dr. Brumbaugh for your child's dental care. Our goal is to provide optimal dental care while incorporating proper dental education which allows kids to remain cavity free. We encourage you to ask questions and be involved in treatment decisions. This includes understanding of any treatment plans as well as our financial policy.

Payment is expected when services are rendered. For your convenience we accept Visa, MasterCard, Discover, and American Express, CareCredit as well as cash or check. We **DO** provide in-office payment plans if needed. If you are in need of a payment option, please see our office manager. Any checks returned to our office as Non-Sufficient Funds will be charged a $40.00 fee per check.

As a courtesy to our insured patients, **we file ALL Dental Insurance Plans**, **however**, ***we are ONLY IN-NETWORK with DELTA DENTAL PREMIER and Guardian!***
Insurance will be filed for all appointments and you will be billed after your insurance pays for any remaining balance that was not covered. That balance is due upon receipt of the statement. If your child is in need of additional treatment a **PRE-TREATMENT ESTIMATE** will be provided BEFORE services are scheduled. This is only an estimate and NOT an exact amount to be paid after insurance. When arriving for your child's treatment appointment, the out-of-pocket amount will be due. If your insurance has not paid within 90 days of services rendered, you will need to make payment in full to our office and will be reimbursed if/when your insurance pays.

Please indicate your understanding and acceptance of these financial policies AND FINANCIAL RESPONSIBILTY FOR THE PATIENT by signing below.

Sign: _____ Date: _____

Consent for Services and Guarantor Agreement
By signing this form, I consent to the use and disclosure of my child's protected health information to carry out treatment, payment activities, and healthcare operations. I hereby authorize Dr. Brian T. Brumbaugh and his staff to perform any and all routine dental procedures for diagnostic/preventative purposes. If additional treatment is needed, an estimate will be presented in the form of a proposed treatment plan.

APPOINTMENT POLICY: All patients are seen on a reserved appointment basis. The procedure you are scheduling requires a definite amount of time be set aside with the dentist. This assures the best possible care for your child. As a courtesy our office provides reminders for upcoming appointments. This is done by email, text message, or telephone call. If your contact numbers change, it is your responsibility to provide updated information for your child's account. All appointments must be confirmed by text, email, or verbally with the office, giving us this courtesy allows us to schedule another patient that needs to be seen, in the event of your cancellation. **ANY APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE WILL BE CONSIDERED A BROKEN APPOINTMENT AND WILL BE CHARGED A $35.00 FEE.** In addition, due to the stringent schedule created for Dr. Brumbaugh, late arrivals may result in the need to reschedule your child's appointment.

I, the undersigned; have read and understand the terms of the above policies.

Signed: _____ Date: _____ Relationship to Patient: _____

Dr. Brian T. Brumbaugh
15 Gosnell Crossing
Staunton, VA 24401

Notice of Privacy Practices Acknowledgement

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. You may refuse to sign this acknowledgement.

I, _____, have received or been offered a Notice of Privacy Practices for the office of Brian T. Brumbaugh. D.D.S., P.C.

_____
Patient(s) Name

_____ _____
Signature Parent/Guardian Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding your child covered under the Privacy Act to people other than yourself.

_____
Patient(s) Name

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding my child/children. (Please list all persons who may bring your child to an appointment, schedule or change an appointment time, or listen to information regarding your child's dental care or treatment),

_____	_____	_____
Print Name	Relationship to Child	Telephone Number
_____	_____	_____
Print Name	Relationship to Child	Telephone Number
_____	_____	_____
Print Name	Relationship to Child	Telephone Number

Parent/Guardian Signature: _____ Date: _____