14420 Sommerville Ct. Midlothian, VA 23113 | Phone: (804) 897-7900
dentist@dentistrichmond.com

Today's date: ____/____/____ **How did you hear about us?** _____

Patient Information (Please Print) Fields with a (*) are required.

Legal Name*: _____
First MI. Last

Preferred name (if different from above): _____ Date of Birth*: _____/_____/_____

Gender*: ☐ Male ☐ Female ☐ Additional Gender not listed: _____

Home Address*:

_____
Street City State Zip

Responsible Party Information (Please Print) Fields with a (*) are required.

Parent/Guardian 1:

Legal Name*: _____
First MI. Last

Date of Birth*: _____/_____/_____ Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address (if different from patient)*:

_____
Street City State Zip

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Email:_____

Employer: _____ Work Phone: _____ Ext:_____

Parent/Guardian 2:

Legal Name*: _____
First MI. Last

Date of Birth*: _____/_____/_____ Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address (if different from patient)*:

_____
Street City State Zip

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Email:_____

Employer: _____ Work Phone: _____ Ext:_____

Insurance Information (Please Print) Fields with a (*) are required.

Primary Dental Insurance:

Employer: _____ Phone No. (____) _____ - _____

Insurance Company*:_____ Group No._____ ID No._____

Subscriber Name*:_____ Subscriber SSN*: _____ - _____ - _____

Subscriber Date of Birth*: ____/ ____/ ____ Relationship to patient*: _____

Insurance Phone Number*: (____) _____ - _____

Ins. Co. Address:

_____
Street or PO Box # City State Zip

As a courtesy we will estimate your portion based on your provider's anticipated reimbursement to us.

Secondary Dental Insurance:

Employer: _____ Phone No. (____) _____ - _____

Insurance Company*:_____ Group No._____ ID No._____

Subscriber Name*:_____ Subscriber SSN*: _____ - _____ - _____

Subscriber Date of Birth*: ____/ ____/ ____ Relationship to patient*: _____

Insurance Phone Number*: (____) _____ - _____

Ins. Co. Address:

_____
Street or PO Box # City State Zip

As a courtesy we will estimate your portion based on your provider's anticipated reimbursement to us.

Medical Insurance:

Employer: _____ Phone No. (____) _____ - _____

Insurance Company*:_____ Group No._____ ID No._____

Subscriber Name*:_____ Subscriber SSN*: _____ - _____ - _____

Subscriber Date of Birth*: ____/ ____/ ____ Relationship to patient*: _____

Insurance Phone Number*: (____) _____ - _____

Ins. Co. Address:

_____
Street or PO Box # City State Zip

Patient Medical Information (Child):

Patient Name:_____ Date of Birth:_____
Primary Care Physician's Name: _____ Phone #: (____)____-_____
Date of last visit: _____ Current physical health ☐ Good ☐ Fair ☐ Poor
Is patient currently under the care of a physician? ☐ Yes ☐ No If yes, explain reason. _____

Is patient taking any medications? ☐ Yes ☐ No
Please list medications, including dosage: _____

_____

Has the patient ever had any of the following medical conditions? ***(Please check columns for YES or NO)***

YES	NO		YES	NO		YES	NO	
		Abnormal Bleeding			Epilepsy/Seizures			Mitral Valve Prolapse
		Alcohol / Drug Abuse			Fever Blisters			Psychiatric Problems
		Anemia			Frequent Headaches			Rheumatic Fever
		Arthritis			Glaucoma			Shingles
		Artificial bones or joints			Heart Murmur			Sinus Problems
		Asthma			Heart Disease			Thyroid Condition
		Blood Transfusion			Hemophilia			Tobacco Use (_____ a day)
		Cancer			Hepatitis			Tuberculosis (TB)
		Colitis			High Blood Pressure			Ulcers
		Dental Anxiety			HIV+/AIDS			Venereal Disease
		Diabetes			Kidney Problems			Other_____
		Emphysema			Low Blood Pressure			

Does the patient have any allergies? ***(Please check columns for YES or NO)***

YES	NO		YES	NO		YES	NO	
		Aspirin			Erythromycin			Sulfa Drugs
		Codeine			Latex			Tetracycline
		Dental Anesthetics			Penicillin			Other Allergies _____

Please describe any conditions indicated above: _____
_____

Please list any additional allergies: _____

Has patient returned from a foreign country within the last 30 days? ☐ Yes ☐ No
Is patient experiencing flu-like symptoms? ☐ Yes ☐ No

Dental History: Why have you brought your child to the dentist today? _____
Previous / Present Dentist: _____ Date of last visit: ____/____/____
Has your child ever had a serious problem associated with any previous dental work? ☐ Yes ☐ No
If yes, please explain: _____
Current dental health: ☐ Good ☐ Fair ☐ Poor Does patient: Suck their thumb or finger? ☐ Yes ☐ No Still drink from a bottle? ☐ Yes ☐ No
Brush daily? ☐ Yes ☐ No Floss daily? ☐ Yes ☐ No Take fluoride supplements? ☐ Yes ☐ No

AUTHORIZATION: I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.
Signature: _____ **Date**: ____/____/____

MIDLOTHIAN FAMILY DENTISTRY USE ONLY: I verbally reviewed the medical/dental information above with the patient named.
Initials _____ Date____/____/____ PATIENT ID NO. _____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY, INITIAL EACH, AND SIGN BELOW

This agreement is between the undersigned and Midlothian Family Dentistry (the "Contract"). Any term of the Contract that may be found unlawful shall be stricken and the remainder of the Contract shall remain fully enforceable and in effect.

____ I understand all patient portions including deductibles and co-pays are due and payable at the time services are rendered.

____ I authorize payment directly to Midlothian Family Dentistry for the benefit otherwise payable to me under the terms of any insurance. I understand any insurance payments will be credited to the account. **I also understand that I am financially responsible for any portion my insurance may not cover for the total treatment fee, or if for any reason my insurance provider does not honor their commitment to either myself or MFD.**

____ I understand that I am to remit any insurance reimbursements paid directly to me by my insurance provider for services rendered within sixty (**60**) days in order to keep my account current.

____ Account balances greater than sixty (**60**) days are assessed a one-time service charge of **$10.00**. A payment is late ("Late Payment") if it is not received within sixty (**60**) days of the date the service was performed. Balances greater than ninety (**90**) days accrue a Default Interest Rate of 1.8% per month (21% per annum). Late Payment acceptance does not revoke a Default under this contract. I agree that Midlothian Family Dentistry has the option but not the obligation to find me in default under this Contract without notice.

____ If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to, an additional thirty-three and one-third percentage (**33 1/3%**) of total balance owed. Late Payments shall be applied first to principle, second to interest accrued and third to any and all attorney fees including court costs, if applicable. For accounts in collections, payments must be made to attorneys. MFD is not authorized to accept payments for accounts turned over to collections.

____ A "payment is a sum of money, which is successfully deposited by Midlothian Family Dentistry against the account balance. A **$35.00** charge is added to the account for checks returned due to insufficient funds.

___ Kleer Plan members enjoy a 20% discount on additional plan services. Plan members must be current to receive the discounts and services included in the membership plan. Payment for treatment not included in the plan is due at the time of service. For members in default status for non-payment of membership fees, payment for services provided by MFD must be paid in full prior to Kleer Plan re-enrollment. Kleer benefits may not be combined with insurance or any other offers or discounts.

____ **I understand that I will be charged a minimum fee of $50 per one-half (1/2) hour for all missed or cancelled appointments unless forty-eight hours (2 business days) notice is given. Please call and speak with one of our Patient Care Coordinators as soon as possible in the event that you need to cancel your appointment.**

Please indicate how you prefer to receive statements: ☐ Email ☐ Paper

NAME*: _____ **Relationship to Patient: _____**

SIGNATURE*: _____ **DATE*: ____/____/____**

Midlothian Family Dentistry Authorization: _____

rev. 11/2/2020

Midlothian
FAMILY DENTISTRY

14420 Sommerville Ct. Midlothian, VA 23113 | Phone: (804) 897-7900
dentist@dentistrichmond.com

Patient Pre-Appointment Questionnaire:

Patient Name:_____ Date:_____

We look forward to seeing you for your appointment. Please take a moment to fill out the questions below so that we can better serve your dental needs.

1. Do you like your smile?

☐ yes ☐ no

_____

_____

2. Are you interested in whiter teeth?

☐ yes ☐ no

_____

_____

3. Do you want straighter teeth?

☐ yes ☐ no

_____

_____

4. If there is one thing you could change about your smile, what would it be?

_____

_____

☺ Thank you for taking the time to fill out this questionnaire ☺

OFFICE USE ONLY:

CLINICAL REVIEWED:_____ DOCTOR REVIEWED:_____

Midlothian
FAMILY DENTISTRY

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Dr. Robert A. Sorenson and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (X-rays), or diagnostic aids.
   - A. Preventative hygiene treatment (prophylaxis) and the application of topical fluoride.
   - B. Application of plastic "sealants" to the grooves of teeth.
   - C. Treatment of diseased or injured teeth with dental restorations (filling and crowns).
   - D. Replacement of missing teeth with dental prosthesis. (Bridges, partial dentures, full dentures.)
   - E. Replacement of missing teeth with dental implants.
   - F. Removal (extraction) of one or more teeth.
   - G. Treatment of diseased or injured oral tissues (hard and/or soft).
   - H. Use of sedative drugs to control apprehension and/or disruptive behavior.
   - I. Treatment of malposed (crooked) teeth and/or oral developmental growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen and analgesia depending on the judgment of the doctor and myself. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. (I am also aware that the nosepieces leave an indentation or ring around the nose, which disappears shortly after the procedure). I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist. And the dentist will explain these.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic material, and treatment records for the purpose of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents, (if the patient is a minor), follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions are followed and the regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient Name: _____ Date: _____ Parent/Guardian Name (if applicable):_____

Signature of Patient, Parent, or Guardian: _____

Midlothian
FAMILY DENTISTRY

14420 Sommerville Ct. Midlothian, VA 23113 | Phone: (804) 897-7900
dentist@dentistrichmond.com

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THIRD PARTY

____initial I understand that this authorization is strictly voluntary, and that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed to the pursuant (s) may be re-disclosed by the recipient to limit the disclosure of confidential protected dental and financial information.

____initial I authorize the release of my confidential protected dental/health information (PHI), financial information and personal information (address, phone number, email, insurance information) to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FOR SHARED ACCOUNTS: I understand that in order for me to share an account with my spouse, my spouse and I must each complete an authorization allowing PHI and financial information to be released to each other. Such authorization is valid for the duration of the shared account until such time whereby each spouse submits a written request for separate accounts to be established and may be changed or revoked at any time, to the extent Midlothian Family Dentistry has already taken action based on the currently dated authorization.

____initial I choose to establish an account with my spouse and have completed the HIPAA Notice of Privacy Practices form.

____initial I choose to establish a separate account from my spouse and have completed the HIPAA Notice of Privacy Practices form.

____initial If I decide to revoke this authorization, I understand that I then must establish a new, separate account and complete new paperwork reversing this decision.

_____ _____
Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

_____
Date

Midlothian Family Dentistry
14420 Sommerville Ct.
Midlothian, VA 23113
Phone Number: (804) 897-7900

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI. This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

This Notice of Privacy Policies takes effect on _____ and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect. We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law.

We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

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

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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 the additional requests. You have the right to request such an accounting in an electronic format.

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

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Practice: Midlothian Family Dentistry
Address: 14420 Sommerville Ct. Midlothian, VA 23113
Telephone: (804) 897-7900
Fax: (804) 897-4048
Email: support@dentistrichmond.com

14420 Sommerville Ct. Midlothian, VA 23113 | Phone: (804) 897-7900
dentist@dentistrichmond.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Midlothian Family Dentistry Notice of Privacy Practices, which has an effective date of _____, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Patient's Representative **Today's Date**

_____
Print Name

_____
Relationship to Patient (If not signed by the Patient)

Coordination of Care Acknowledgement

The doctors and staff at Midlothian Family Dentistry take your overall health seriously. There are several things we may need to ensure we are taking as much into consideration as possible prior to certain treatment.

Part I - Consulting with your Primary Care Physician and/or Treating Physicians

We may need to contact your primary care physician to address whether you are a candidate for certain procedures. We will need your permission to request this information from your doctor, or we may be unable to proceed with the treatment.

I request and hereby authorize the release of my medical/health information from my physician, to Midlothian Family Dentistry, in order to determine my ability to receive dental treatment and/or sedation.

Patient Name	Patient or Guardian Signature	Date

Part II - Managing Medications / Prescriptions

It is important that we are informed of all medications you may be taking prior to prescribing medications, or providing certain treatments. We can now automatically obtain your prescription history from the Virginia Prescription Monitoring Program (PMP) when deemed necessary. It will make it easier for you to share your medical history with us and give us the ability to provide you with better, more efficient quality care.
In order to take advantage of this program, we will require your permission.

I hereby give permission to MIDLOTHIAN FAMILY DENTISTRY to obtain my prescription history directly from PMP.

Patient Name	Patient or Guardian Signature	Date

There may be times when Midlothian Family Dentistry may need to phone in a prescription for you. For your convenience, we can save your preferred pharmacy in our system.
Please indicate that pharmacy here:

Pharmacy Name	Location	Phone Number