Toothbeary Pediatric Dentistry
Dr. Darchelle Braxton

Patient Information

Patient Name:_____Preferred Name: _____

Gender (M/F): _____ Birth Date: _____Age_____

Address: _____ _____

_____ Phone #: _____

Father's Name:_____ _____

Date of Birth: _____ Social Security #: _____

Address if different from child: _____ _____

Phone #:_____Marital Status: _____

Occupation: _____ Employer: _____

Work #: _____ Cell #:_____ Other #:_____ E-mail address: _____

Mother's Name: _____ _____

Date of Birth: _____ Social Security #: _____

Address if different from child: _____ _____

Phone #: _____Marital Status: _____

Occupation: _____ Employer: _____

Work #: _____ Cell #:_____ Other #: __ _____ E-mail address:_____

With whom does the patient live? _____

Whom may we thank for referring you to our office? _____

Insurance Information

PRIMARY INSURANCE

Subscriber's Name: _____ _____

Date of Birth: _____ Social Security #: _____

Insurance Plan Name: _____Address: _____

Insurance Plan Phone # _____ _____

Identification #: _____ Group#: _____

SECONDARY INSURANCE

Subscriber's Name: _____ _____

Date of Birth: _____ Social Security #: _____

Insurance Plan Name: _____Address: _____

Insurance Plan Phone # _____ _____

Identification #: _____ Group#: _____

I accept financial responsibility for all services rendered to my child. The parent or guardian bringing the patient to our office is responsible for payment of the account in full on the day treatment is rendered. I authorize the release of any medical information to process my insurance claims or payment assigned to Dr. Darchelle Braxton, Toothbeary Pediatric Dentistry, and her associates. This office will assist in the prompt filing of all insurance forms; however, I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for any services not covered by my policy. In the event of default on my account, I agree to pay collection costs including attorney's fees and court costs which may represent one third of the balance due.

Signed _____ Date _____

PATIENT NAME_____

Medical Health History

Condition of child's general health: _____

Child's Physician: _____

Phone #: _____

Family Dentist:_____

Phone #: _____

PLEASE CHECK EACH BOX INDIVIDUALLY

Yes No

( ) ( ) Does your child have regular medical exams?
( ) ( ) Is your child up to date with immunizations:
( ) ( ) Has your child been hospitalized? Date_____ Reason _____
( ) ( ) Has your child ever had general anesthesia or sedation for medical reasons? Date _____Reason _____
( ) ( ) Is your child presently taking medications? If so, what? _____
( ) ( ) Has your child ever had blood transfusions:
( ) ( ) Is your child presently undergoing any medical treatment? If so, what? _____
( ) ( ) Is your child presently undergoing chemotherapy?
( ) ( ) Does you child have an infectious or chronic disease? If so, what? _____
( ) ( ) Does your child smoke or use tobacco products?
( ) ( ) Is your child allergic to any Medicine? If so, what? _____
( ) ( ) Is your child allergic to Latex?
( ) ( ) Has your child experienced any unfavorable reactions from previous dental or medical care?
If yes, please explain: _____

Has your child ever been diagnosed as having any conditions of the following:

Yes	No		Yes	No		Yes	No	
( )	( )	Blood-Circulatory	( )	( )	Gastrointestinal-Stomach	( )	( )	Muscles
( )	( )	Bones	( )	( )	Kidney-Bladder	( )	( )	Nervous System
( )	( )	Endocrine Glands	( )	( )	Heart	( )	( )	Prosthetic Valves & Joints
( )	( )	Eyes, Ears, Nose	( )	( )	Liver	( )	( )	Skin Throat
( )	( )	Respiratory	( )	( )	Tonsils/Adenoids			

If yes, please explain._____

Yes	No		Yes	No		Yes	No	
( )	( )	AIDS	( )	( )	Eye Problems _____	( )	( )	Pregnant
( )	( )	Anemia	( )	( )	Excessive Bleeding Problems	( )	( )	Psychiatric Disorder
( )	( )	Allergy	( )	( )	Fainting	( )	( )	Rheumatic Fever
( )	( )	Arthritis	( )	( )	Hearing Loss	( )	( )	Scarlet Fever
( )	( )	Asthma	( )	( )	Heart Disease/Hear Murmur	( )	( )	Scoliosis
( )	( )	Autism	( )	( )	Hemophilia	( )	( )	Sickle Cell Anemia
( )	( )	Brain Injury	( )	( )	Hepatitis- Type _____	( )	( )	Sinus Problems
( )	( )	Bronchitis	( )	( )	Hyperactivity	( )	( )	Frequent Sore Throats
( )	( )	Cancer	( )	( )	Jaundice	( )	( )	Speech Therapy
( )	( )	Cerebral Palsy	( )	( )	Kawasaki Disease	( )	( )	Spina Bifida
( )	( )	Chicken Pox	( )	( )	Leukemia	( )	( )	Syndrome _____
( )	( )	Cleft Lip/Palate	( )	( )	Measles	( )	( )	Tetanus
( )	( )	Convulsions/Seizures	( )	( )	Mumps	( )	( )	Tuberculosis
( )	( )	Diabetes	( )	( )	Mouth Breathing	( )	( )	Venereal Disease
( )	( )	Diphtheria	( )	( )	Nutritional Deficiency	( )	( )	Whooping Cough
( )	( )	Drug or Alcohol Abuse	( )	( )	Orthopedic Problems	( )	( )	Other _____
( )	( )	Epilepsy	( )	( )	Polio			

Dental Health History

Yes No

( ) ( ) Does your child have a dental condition about which you are especially concerned? Explain_____
( ) ( ) Is this your child's first visit to the dentist? If not, date of last dental care_____
( ) ( ) Has your child ever received injuries to the head, jaw, mouth or teeth? Explain _____
( ) ( ) Does your child have a toothache?
( ) ( ) Was your child a thumb/finger sucker? Age discontinued _____
( ) ( ) Did your child use a pacifier? Age discontinued _____
( ) ( ) Was your child bottle fed? Age discontinued_____
( ) ( ) Was your child breast-fed? Age discontinued_____
( ) ( ) Is your child a mouth breather?
( ) ( ) Does your child grind or clinch his/her teeth?
( ) ( ) Does your child's gums bleed?
( ) ( ) Is your child presently taking a fluoride supplement? If so, what? _____
What is your water source? Public System _____ Private Well _____ Reverse Osmosis System _____
How often are your child's teeth brushed per day? _____ By whom? _____ What type toothpaste? _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment. I certify that I have read and understand the above questions. I will not hold Dr. Darchelle Braxton, Toothbeary Pediatric Dentistry, or her staff responsible for any errors or omissions I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Parent of Legal Guardian Relationship to Patient Witness Signature Date

Toothbeary Pediatric Dentistry
Dr. Darchelle Braxton

Diagnostic and Preventative Consent

Patient's Name _____ Date of Birth_____

1. I request and authorize Dr. Darchelle Braxton, Toothbeary Pediatric Dentistry, and other health care professionals on her staff to perform or assist in the performance of regular dental care.

2. I understand these procedures involve cleanings, necessary x-rays, fluoride treatments when applicable. The purpose of these procedures is to maintain dental health, although no guarantees or assurances of any sort as to these results may be obtained.

3. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatments in terms appropriate to their age.

4. I understand if any treatment other than the above is required; it will be discussed with me before beginning such treatment.

5. I authorize the use of photographs, radiographs, or other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

6. I understand I may refuse to consent to any and all treatments or procedures specified above or discussed with me. My right to refuse to consent to anything can be designated in this form by drawing a line through the objectionable word, sentence or paragraph, and writing my initials next to the portion to which I refuse to consent. I am free to indicate anything not mentioned herein, but to which I refuse to consent at the end of this form.

7. I certify that I have read the above. I acknowledge that the dentist has explained the above to me in a thorough and comprehensible manner and that my questions have been answered to my satisfaction.

_____

Signature of Parent or Legal Guardian Date

_____ _____

Relationship to Patient Witness

Toothbeary Pediatrics Dentistry
Dr. Darchelle Braxton

Consent for Dental Treatment

Patient's Name_____ Date of Birth_____

I request and authorize Dr. Darchelle Braxton, Toothbeary Pediatric Dentistry, and other health care professionals on her staff to perform or assist in the performance of the following but not necessarily limited to:

- Dental Examinations
- Prophylaxis (Cleaning), Necessary X-rays, Fluoride Treatments
- Fillings
- Sealants
- Extractions/Oral Surgery
- Space Maintenance/Interceptive Orthodontics
- Crowns
- Endodontics/Nerve Treatments
- Emergency Dental Treatment
- Other

I understand that unforeseen conditions or circumstances may arise during the course of the above-described procedure or treatment. Hence, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist reasonably believes necessary or advisable as a result of these unforeseen events.

The purpose of the above is to maintain dental health and we anticipate that result. No guarantees or assurances can be made as to the results that may be obtained.

Bleeding, swelling, discomfort, and bruising can occur after any dental procedure. The risk of not completing necessary dental treatment can result in abscess, infection, pain, fever, swelling and substantial risk to the developing permanent teeth.

I consent to the administration of local anesthetic that the dentist deems necessary, and/or nitrous oxide. I understand that the risks involved with the administration of local anesthetics may also be characterized by excitation, depression, nervousness, dizziness, blurred vision, tremors, drowsiness, convulsions (seizures), unconsciousness and possibly cardiac/respiratory arrest. Allergic reactions may occur which may be characterized by skin eruptions, itching, and swelling. I understand that the alternative of not using local anesthetic would probably cause a great deal of discomfort. The risk of this alternative could be emotional damage.

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tones.

I understand that should the child become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such movements, it may be necessary to use physical restraints such as a papoose board. The parent or guardian will be informed of the need for physical restraint will be asked to assist placing their child in such restraint.

My signature below signifies I authorize the use of physical restraint, when deemed necessary to avoid possible injury to the child.

I understand that I may refuse to consent to any and all treatment. I have crossed out and initialed anything that I would refuse to consent to.

I certify that I have read and understand the above. I accept the risk of substantial and serious harm, if any, in hope of obtaining the desired beneficial results of this treatment or procedure. I acknowledge that the dentist has explained all of the above to me in a thorough and comprehensible manner, and that my questions about my treatment and its attendant risks have been answered to my satisfaction.

Signature _____ Relationship to Patient _____

Date _____ Time _____

Witness _____

Toothbeary Pediatric Dentistry

Dr. Darchelle Braxton

FINANCIAL AGREEMENT

Patient Name(s): _____

1. If you do not have dental insurance, **payment in full is expected at the time of your visit**. We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash.

2. If insurance is available:

· Please provide us with your insurance card - no claim will be processed without proper certification of dental insurance. Payment will be expected at time of service.

· All deductibles and co-payments must be paid at your initial visit. Refer to your benefits booklet for details.

· Please be aware that insurance companies have contracts between you and your employer. Payment is based on your specific plan. If questions arise regarding your coverage, contact your insurance company or your human resources officer at your employment.

· We will collect from you any balances not covered by your insurance at the time services are rendered.

· It typically takes between 14-45 days for us to receive payment from your insurance company. We then apply that payment and bill any remaining balance to you, which is due upon receipt of statement.

· We will submit a claim on your behalf two times. If your insurance company has not paid your claim within 60 days of your visit, you will need to make payment in full for that visit. We will provide you with a claim form to seek reimbursement directly from your insurance co.

· Some insurance carriers arbitrarily select certain services they will not cover. It is up to you, the patient, to know what these services are.

· Account balances are due upon receipt of your statement. A monthly finance charge of 1.5% will be assessed to any balance 25 days past due. We may require pre-payment for future appointments should account not be kept current.

· Collection costs and attorney's fees will be charged to your account should it become delinquent.

· We will assist in filing a predetermination estimate at your request. Predetermination is not a guarantee of insurance benefits.

3. We accept cash, check, credit cards (Visa, MasterCard, Discover and CareCredit.) Ask us for more information about CareCredit.

4. A $50 processing fee will be assessed for returned checks._____initial

5. Please be considerate to our staff and practice. If you are unable to make your appointment, please reschedule so that someone else may have your appointment.

6. We require 24 hours notice (1 business day) to reschedule your appointments. A broken appointment fee ($50) may be assessed if we do not hear from you within this time frame to reschedule your appointment. We require 48 hours notice (2 business days) to reschedule sedation appointments. A broken appointment fee ($75) may be assessed if we do not hear from you within this time frame to reschedule your appointment.

7. This applies to all family members and by signing this I acknowledge that I am signing on behalf of all family members.

8. No personal checks accepted exceeding $50. _____initial

I have read and agree to the above (a copy will be provided to you upon request).

Sign, then print full name_____Date_____

Witness _____ _____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name/Names of Patients _____

Please Print Legal Guardian Name _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU, WHICH IS PROTECTED UNDER THE HIPAA PRIVACY RULE MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION.

THE EFFECTIVE DATE OF THIS NOTICE IS May 1, 2016
PLEASE REVIEW THE FORM CAREFULLY. THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of Toothbeary Pediatric Dentistry

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To protect the privacy of your medical information. We provide benefits to you as described in your benefits literature. As a result of offering benefits, we are required to follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice at any time. If we make changes to this notice, we will revise it and send a new notice to all covered persons at that time. We reserve the right to make any changes apply to all your protected health information maintained before and after the effective date of the new notice.

Purposes for which We May Use or Disclose Your Protected Health Information Without Your Consent or Authorization

We may use and disclose your protected health information for the following purposes:

- *Treatment*. For example, we may disclose your protected health information to determine if a medical condition is pre-existing or for the pre-certification of care.
- *Payment*. For example, we may use or disclose your protected health information to business associates or insurance carriers for the payment of claims or to provide eligibility information to your doctor when you receive treatment.
- *Health Care Operations*. For example, we may use or disclose your medical information (i) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (ii) to authorize business associates to perform data aggregation services (iii) to perform normal employee benefits operations.
- *As Required By Law*. For example, we must allow the U.S. Department of Health and Human Services to audit Plan records. We may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.
- *To Business Associates*. We may disclose your medical information to business associates we hire to assist us. Each business associate must agree in writing to ensure the continuing confidentiality and security of your medical information.
- *Sale of Business*. In the event that the company is sold or merged with another organization, your protected health information will become the property of the new owner.

We may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give us your agreement.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosure Requiring Your Authorization

Certain uses and disclosures require your specific authorization to include if applicable, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and any sale of PHI. Sale of PHI refers to any direct or indirect remuneration tied to disclosure of PHI with certain exceptions such as for public health purposes, purposes for treatment or payment, research with reasonable cost-based fee, disclosure to business associate to perform services, if only remuneration is for the services, individual requested disclosures, or disclosures required by law.

Uses and Disclosures with Your Permission

We will not use or disclose your medical information for any other purposes unless you give your written authorization to do so. Genetic information is not permitted to be used or disclosed for underwriting purposes (if applicable). Genetic information includes genetic tests and manifested diseases or disorders of you and your family members. If you give written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information we maintain, unless we have taken action in reliance on your authorization.

Your Rights

You may make a written request to do one or more of the following concerning your protected health information that we maintain:

- To put additional restrictions on the use and disclosure of your medical information. We do not have to agree to your request.
- To obtain an electronic copy of PHI. The electronic copy may be provided in the form and format requested by you or if not readily available, then you may receive electronic PHI in a mutually agreeable machine readable format such as MS Word, Excel, PDF or HTML. In limited cases, we do not have to agree to your request.
- To be notified of a breach of unsecured PHI.
- To communicate with you in confidence about your medical information by a different means or at a different location than we are currently doing. We do not have to agree to your request unless such confidential communications are necessary to avoid endangering you. Your request must specify the alternative means or location to communicate with you in confidence.
- To see and get copies of your protected health information. In limited cases, we do not have to agree to your request.
- To correct your medical information. In some cases, we do not have to agree to your request.
- To receive a list of disclosures of your protected health information that we and our business associates made for certain purposes for the last 6 years (but not for disclosures before the date your coverage began).
- To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). We will give you the necessary information and forms for you to complete and return to the Contact Office.

Complaints

If you believe your privacy rights have been violated, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us as indicated below:

TOOTHBEARY PEDIATRIC DENTISTRY
Telephone: (804) 709-8166
Email: www.toothbearykids.com
Address: 4300 Pouncey Tract Road Henrico, VA 23060

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