Patient Information

Date:_____/_____/_____

Patient Name: ___________________________________Preferred Name: _________________________

Patient Gender (circle): Male / Female / Non-binary

How did you hear about us?

____ Referred by Doctor
Who?______________________
____ Referred by Family/Friend
Who?______________________
____ Insurance
____ Mailer
____ Facebook
____ Instagram
____ Twitter
____ Other:____________

Parent/Guardian Name (present for appointment): __________________Marital Status: __S__M__D__W__P

Relationship to Patient (circle): Mother Father Stepfather Stepmother Grandfather Grandmother Legal Guardian Institutional Rep

Home Address: ____

City: ______________________________ State: _______________ Zip Code: ______________________

Home Phone : (______)_____________________ Cell Phone : (______)__________________________

Best Contact Number: Home Cell

Patient Date Of Birth : __________/_________/_________ Guardian SSN : _________-________-_________

Guardian Employer: ___________________________________ Work Phone: (______)__________________

Email Address: ____

Emergency Contact: ___________________________________ Phone: (______)____________________

If you are covered by Dental Insurance, Please complete the following:

Name of Insurance Company **(Primary)**: ____

Name of Policy Holder: ____

Employer (If through Occupation): ____

Date Of Birth : _____/_____/_____ SSN : _______-______-_______ Group Number: _________________

Name of Insurance Company **(Secondary)**: ____

Name of Policy Holder: ____

Employer (If through Occupation): ____

Date Of Birth : _____/_____/_____ SSN : _______-______-_______ Group Number: _________________

If you are not covered by Dental Insurance, would you like to learn more about our Bitty Bites Membership Plan? We offer a membership plan to give 2 cleanings, 2 fluoride treatments, radiographs, and discounted restorative treatment for one flat fee per year.

_______**Yes, I would like to learn more.**

______ **No, thank you, I have dental insurance or will pay out-of-pocket for dental fees**

Authorization and Release of Information:

I agree that my dental insurance carrier may be billed for services provided and payment will be made directly to Bitty Bites Pediatric Dentistry. I also assume responsibility for any portion of the treatment cost not covered by my insurance carrier. I hereby give authorization for the release of any information requested or required by my insurance carrier with respect to any insurance claims.

Patient/ Parent/ Guardian Signature: ________________________________Date: __________

Patient Information

Health History Information **Patient Name:**______________________

Do you have any **allergies** to the following: ☐ Latex ☐ Penicillin ☐ Aspirin ☐ Codeine

Other: ____

Check any of the following which apply to the patient present or past:

**☐ Known allergy to dogs	**☐Known fear of dogs	
☐ OCD	☐ Autism	☐ Depression
☐ Anxiety	☐ Genetic Issue________________	☐ ADHD
☐ Abnormal/excessive bleeding	☐ Diabetes	☐ Low Blood Pressure
☐ Anemia	☐ Epilepsy	☐ Mitral Valve Prolapse
☐ Arthritis	☐ Heart Murmur	☐ Open Heart Surgery
☐ Pacemaker	☐ Artificial Joints	☐ Heart Trouble
☐ Pre-mature Birth	☐ Asthma	☐ Hepatitis A__ B__ C__
☐ Radiation Treatment	☐ Blood Disease	☐ High Blood Pressure
☐ Respiratory Disease	☐ Cancer____________________	☐ HIV / AIDS
☐ Rheumatic Fever	☐ Chemotherapy	☐ Jaundice
☐ Sleep Apnea	☐ Cold Sores/Fever Blisters	☐ Kidney Disease
☐ STD _______________________	☐ Congenital Heart Lesions	☐ Liver Disease
☐ Tuberculosis	☐ COPD	

Do they take blood thinners or aspirin daily?______________ Are they nursing or pregnant?___________

Any unusual reaction to Local Anesthesia? If yes, explain ____

Any history of bisphosphonate use? To treat osteoporosis or similar diseases?____________________________

Any hospitalizations in the last two years? If yes, explain____

Any surgeries in the last two years? If yes, explain ____

Name of Physician :____ Phone Number:(____)______-_______

Date of last visit:__________________ Reason for visit:____

Behavioral Concerns (For example: ADHD, Autism, OCD, Depression, and/or anxiety): ______________________

____

List medications, dosage, and reason for taking:

Medications	Dosage	Reason for taking
____________________________	______________________	___________________________
____________________________	______________________	___________________________
____________________________	______________________	___________________________
____________________________	______________________	___________________________

Remarks:____

____

Patient/ Parent/ Guardian Signature: ________________________________**Date:** ___________

Patient Information

Dental Information **Patient Name:**________________________________

What is your primary concern for today's visit?

____

Date of their last dental visit? ______________________ Name of Dentist? __________________________________

Any history of dental trauma?____

Do they have any broken teeth or teeth causing discomfort? ____

Have they ever had an unpleasant dental experience, if yes please explain? _________________________________

____

Do their gums bleed easily? ____________________ If yes when? ____

Do they have any discomfort in your jaw? _____________ Do they clench or grind their teeth? _________________

Do they smoke or use tobacco products?_______________ Have they ever had orthodontic treatment?___________

Have they ever used a product to whiten their teeth?_______ If yes, when and what product?___________________

Do they like their smile? ______________________ List any changes to their smile they would like to change: _____

____

****IMPORTANT*** Consent:***

All children under 18 must be accompanied by a parent or legal guardian for their appointments. It is our office policy that a parent or legal guardian be present. Parents/legal guardians can stay in the waiting room or in the treatment room until the appointment is complete, at this time the technician will review the completed appointment with the parent/guardian. If your child is brought by any other person other than the ones listed below they will be asked to reschedule. Furthermore, due to HIPPA regulations (confidentiality laws), we cannot discuss treatment with anyone other than a parent or legal guardian unless permission to discuss protected health information listed on the patient consent form has been filled out. Once patient turns 18 years of age we are no longer obligated to discuss treatment or account information with anyone but the patient, unless consent form is signed by the patient.

I give consent for the following people to bring my child to office visits at Bitty Bites Pediatric Dentistry and I consent to the examination and /or treatment of my child in my absence.

Name: ____ Relationship: ☐Mother ☐Father ☐Guardian ☐________

Name: ____ Relationship: ☐Mother ☐Father ☐Guardian ☐________

Name: ____ Relationship: ☐Mother ☐Father ☐Guardian ☐________

My consent to disclosure of records shall be effective until I revoke it in writing.

Patient/ Parent/ Guardian Signature: __________________________________**Date:** ___________

Pediatric Dentistry Informed Consent

Patient Name:_________________________________ Date:____________________ DOB:____________________

To eliminate the presence of dental decay, the following treatment(s) are recommended for your child. The common risks or complications of such treatment are also listed. Please ask any questions you may have prior to signing this form. **By signing this form below you are indicating that you understand the nature of the proposed treatment, the risks and alternatives to such treatment, and the consequences of not undergoing treatment. You are further indicating that all of your questions have been answered to your complete satisfaction, and that you believe it to be in your child's best interest to proceed with the proposed treatment. Please note that it is not possible to predict or guarantee the outcome of the treatment.**

1. **Proposed / Recommended Treatment:** Radiographs (x-rays), restorations / fillings (tooth colored fillings), composite or resin crowns, extractions, root canal therapy (nerve treatment- pulpotomy / pulpectomy), stainless steel crowns, prophylaxis (cleanings / scaling), fluoride treatment, sealants, space maintainers, and / or other:____
2. **Benefits and Alternative Treatments:** Removing decay and restoring teeth or removing teeth and placing space maintainers (where indicated) allows for more optimal oral health. This allows for better mastication (chewing), speech, and overall health. It also helps the permanent teeth erupt in a more favorable position. Alternatives to treatment include: **A)** Do nothing- Observing / watching the decay process- This allows the decay to continue and may lead to infection and / or space loss / extractions. **B)** Extracting the decayed tooth, even if it can be saved. **C)** Not placing a space maintainer where required may lead to space loss and crowding. All alternatives require compromises that may affect your child's overall dental and medical health.
3. **Common Risks:** more common risks include BUT are not limited to: **A)** Allergy to latex used in some dental gloves. **B)** Allergy to local and topical anesthetics used. **C)** Allergy to filling materials. **D)** Biting or excessive rubbing of the cheek, lips, or tongue when numb which may lead to redness, bleeding, or scarring. **E)** Infection. **F)** Further decay requiring additional treatment. **G)** Tooth loss. **H)** Paresthesia (loss of sensation). **I)** Sensitivity to temperature (when biting / chewing). **J)** Space loss.
4. **Consequences of not performing the Recommended Treatment:** Dental Caries is and is in infectious process; it may spread from tooth to tooth and will enlarge if left untreated. Should the decay process continue unchecked, additional teeth may become decayed and / or prematurely lost. Decayed teeth may become reduced in size which may cause space loss necessitating orthodontic therapy.

Every reasonable effort will be made to ensure that your child's dental condition is treated properly although it is not possible to guarantee results.

________ **I give my consent for the proposed treatment.**

________ **I refuse to give my consent for the proposed treatment and acknowledge that I have been informed of potential consequences of my decision to refuse treatment.**

____ ______________________________

Parent / Guardian Name Printed **Date**

CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Bitty Bites Pediatric Dentistry is to provide you and your child with convenient, accessible, and high quality dental care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive on time for all scheduled appointments or cancel the appointment at least 24 hours in advance. This policy allows us to make better use of available appointments for those patients in need of dental care.

Cancellation of an Appointment

You may cancel your scheduled appointment through text or calling (804) 215-8600 or emailing info@bittybitespediatricdentistry.com

Appointments are in high demand and your early cancellation will give another child the opportunity to be seen by a provider.

Missed Appointment Policy

A “missed appointment” is when someone does not show up for an appointment and does not cancel 24 hours in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment 24 hours in advance, this will be recorded as a "missed appointment".

If you miss your appointment, you will be notified by telephone or email and asked to re-schedule.

Fees for Appointments – Financial Agreement

Effective March 1st, 2020, Bitty Bites Pediatric Dentistry will begin to charge patients when they miss scheduled appointments.

Failure to cancel or re-schedule the appointment within 24 hours of the scheduled appointment time will result in a fee for the missed appointment. This fee will not be submitted through the health plan; it will be charged directly to the patient.

More than 2 missed appointments will be reason for dismissal from the practice.

We understand that flexibility is important and patients may be allowed one “Free” missed appointment.

The missed appointment fee is $25 for all types of appointments.

Signature of Parent or Guardian ______________________ Date _________________

Patient Name ______________________

PATIENT HIPAA 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.

I authorize the following individuals to present with my child in my absence and for you to release protected health information to them:

Print patient's full name ____

Guardian Name____________________________ Relationship to Patient ________________________

Signature __________________________________ Date___________________________

THERAPY DOG CONSENT FORM

Animal-Assisted Therapy (AAT) is a form of creative therapy that utilizes credentialed therapy animals and handlers (people who manage the animal) to provide goal-directed interventions to individuals of all ages. Bear, our therapy dog, is certified through the Alliance of Therapy Dogs and AKC Canine Good Citizen courses to work in our office setting. Although working with animals, specifically canines, in a therapeutic setting has many benefits, there are risks associated with the intervention. Because AAT utilizes a live animal, it is important to note in advance the policies and procedures to maximize the intervention and ensure a safe environment, both for the dog and the patient.

1. Interaction with Bear is not required can be opted out of; depending on Dr. North's (handler) assessment it is not guaranteed every child will be allowed interaction with the therapy dog
2. Should the patient become aggressive (hits, bites, pulls, pinches, etc) toward the therapy dog, Dr. North will remove the therapy dog and determine if any further interaction is allowed
3. Anyone wishing to participate in AAT should not have allergies, skin or respiratory sensitivities, or other medical conditions related to dogs; Dr. North & Bitty Bites Pediatric Dentistry can not be held liable for allergic or other physiological reactions to the therapy dog
4. Any fear of dogs must be reported before treatment commences for proper precautionary measures
5. If sick or injured, the therapy dog will not be able to provide services until the illness or injury subsides or upon veterinary approval
6. Although the therapy dog will remain current on his vaccinations and health screenings, there is always a slight risk of zoonotic disease transmission (i.e. the sharing of diseases between animals and humans) when working with an animal, every effort will be made by Dr. North to reduce the risk of zoonosis
7. Direct contact with the animal's urine, stool, and/or blood should be avoided. Every effort will be made by Dr. North to educate/model for the patient and/or guardian appropriate ways to physically engage with the therapy dog
8. All patients must either wash their hands or use hand sanitizer before and after touching the therapy dog
9. The therapy dog will be well-groomed and although every effort will be made to cut and file the therapy dog's nails, scratching may occur while physically interacting with the dog. Neither Dr. North nor Bitty Bites Pediatric Dentistry can be held liable for injuries incurred by the therapy dog's nails

THERAPY DOG CONSENT FORM

10. Dogs play or show affection by licking or nibbling, which may result in oral contact from the dog.. Although every effort will be made by Dr. North to monitor this, there is a risk for light biting or zoonotic disease transmission to occur when a dog makes oral contact with a person.. The therapy dog will be allowed to lick the patient upon obtaining the parent's/legal guardian's verbal permission noted in patient's file. Neither Dr. North nor Bitty Bites Pediatric Dentistry can be held liable for injury or zoonotic disease transmission as a result of oral contact from the therapy dog
11. Dogs use their body to communicate and may brush against or lean into a person.. Other body language such as tail wagging or body wiggling can occur, such behaviors create a risk for loss of balance, falling, or light bruising. Neither Dr. North nor Bitty Bites Pediatric Dentistry can be held liable for injuries incurred by physically engaging with the therapy dog.
12. The patient and/or guardian will promptly report all accidents and/or injuries to Dr. North. Should injury occur, Dr. North will respond accordingly and take proper action to help the patient get the appropriate medical care.
13. The therapy dog cannot be used in therapy without Dr. North present. No other provider is credentialed to handle the therapy dog.
14. Patients are never to be left alone with the therapy dog.
15. If at any time, the therapy dog shows signs of distress, irritation, fear, or in any way acts in a negative manner, he will be allowed to take a break. No one, except Dr. North, should touch or interact with the therapy dog during these times. Dr. North will assess and determine whether it is safe for the therapy dog to return to the session.
16. Animals, like people, have their own moods that determine their level of desire to interact with others.. It is therefore understood that the therapy dog is allowed to determine if and when to participate in therapy. While it may be planned to use the therapy dog in a session, the therapy dog will never be forced to participate/interact with others.
17. The therapy dog has a designated space in the office where he is free to rest, sleep, or take a break without interruption.
18. If Dr. North and the patient/legal guardian agree, the therapy dog may work off leash, which will be noted in the patient's file.

THERAPY DOG CONSENT FORM

I DO CONSENT TO THE USE OF THERAPY DOGS

I understand and agree to the policies, procedures, and risks associated with Animal-Assisted Therapy during dental treatment. I hereby consent to therapeutic services involving a therapy dog, provided for my child by Lindsey North, DDS, MS, and accept full liability in the event that the therapy dog causes injury to my child in any way throughout the course of the office visit. Furthermore, I am not aware of any fear, allergy, skin or respiratory sensitivity, or other medical condition my child(ren) has/have that would render physical interaction (i.e. touching, handling) with or close proximity to a therapy dog potentially harmful for his/her health.

Print patient's full name ____

Guardian Name__________________________ Relationship to Patient ______________________

Signature ________________________________ Date_________________________

or

I DO NOT CONSENT TO THE USE OF THERAPY DOGS

I wish to have my child scheduled on days without therapy dog interaction.

Print patient's full name ____

Guardian Name__________________________ Relationship to Patient ______________________

Signature ________________________________ Date_________________________

Illness Policy

To ensure the health of all our patients and staff we ask that when a patient is sick they call to reschedule. If a medical provider makes a specific diagnosis, please let us know. The following criteria are outlined to assist you in deciding when to reschedule because of illness:

- **Fever related to illness within a 24 hour period prior to scheduled appointment**
- **Contagious disease**, such as Chicken Pox or Coxsackie virus (hand, foot, and mouth disease)
- **Lice, ringworm, or scabies** that is untreated and contagious to others
- **Upper respiratory infections** (ear, nose, throat)
- **Conjunctivitis** (pink or red eyes with thick mucus or pus draining from the eye.) Patient may be rescheduled 24 hours after prescription treatment begins
- **Diarrhea with illness** (vomiting, fever, and or rash) - <u>Patient may be present if diarrhea is not illness related, I.E. caused by antibiotics or food sensitivity</u>
- **Undiagnosed rash or a rash attributable to contagious illness or condition**
- **Skin sores which are open and draining** (including such things as impetigo, etc.)
- **Strep Throat** – We are able to see patient once patient has been on an antibiotic for 24 hours and had no fever for 24 hours
- **Vaccine Preventable Diseases** (Mumps, Measles, Whooping Cough, etc.) - Patient may return after he or she is judged not infectious by a medical provider
- **Vomiting** (Two or more episodes in the past 24 hours) – Until vomiting resolves or a health care provider determines that the cause is not communicable the patient should not be seen

We appreciate your cooperation with our illness policy. By signing below, you understand that we cannot see the patient with any of the above illnesses listed. **If we have any reason to believe that the patient has any of these illnesses please understand that we may respectfully ask you to reschedule the appointment.** In some cases, a note from the physician may be required.

______________________________	______________________	____________________
Patient/Parent/Responsible Party Signature	Relationship to Patient	Date

Media Consent

I consent that Bitty Bites Pediatric Dentistry may use photographs or videos of me or my child taken beginning on the date indicated below, on their social media tools which includes, but not limited to their Facebook page, Instagram, and Twitter. I understand that these images and/or videos will not be used for any other commercial purposes.

Name (please print):____

Signature: ____

Date: _________/_________/_________

If person(s) in photos/videos is a minor, please print name(s) below.

Name of Minor(s) (please print): ____

____

____

____

Parent/Guardian Signature: _______________________________________ Date: _____/_____/_____