Welcome to Texas Tooth Fairies Pediatric Dentistry

NP

PATIENT INFORMATION

Patient Name: _____ _____
First Middle Initial Last Nickname

Date of Birth: _____ **Age:** _____ **Gender:** Male/Female

Medical History:

Child's Physician: _____ Phone# _____When was the last visit? _____

- Is your child in general good health? **YES/NO**
- Are they up to date with Immunizations? **YES/NO**
- Is your child **allergic** or had any **adverse reaction** to a medication? **YES/NO**
  If YES, please Explain: _____
- Does your child have any additional **allergies** (i.e. Latex, Seasonal Allergies, Food Allergies, Drug Allergies)? **YES/NO**
  If YES please explain: _____
- Does your child have **breathing problems** or **asthma**? **YES/NO**
  Has your child been to the ER for an **Asthma Attack**? **YES/NO**
  What induces a **breathing problem**? _____
  What **Asthma Medication(s)** does your child take? _____
- Is your child taking any **medications**? **YES/NO**
  If YES, please list medications, dosage, and reason for medication: _____
  _____
- Does your child have any **physical disabilities**? **YES/NO**
  If YES, please explain_____
- Does your child have any **developmental disabilities (speech/vision/hearing/other)**? **YES/NO**
  If YES, please explain_____
- What type of learner is your child: ❑ADVANCED ❑PROGRESSING NORMALLY ❑SLOWER LEARNER
- Has your child ever had an **operation, been hospitalized or treated in an emergency room**? **YES/NO**

Mark Yes OR No to each:

Yes No ADD/ADHD
Yes No Autism Spectrum
Yes No Sensory Integration Issues
Yes No Nervous or Emotional Disorders
Yes No Eating Disorders
Yes No Mental/Emotional Problems
Yes No Heart Trouble or Heart Murmur
Yes No Rheumatic Heart Disease or Fever
Yes No Blood Disease or Anemia
Yes No Hemophilia/Von Willebrand
Yes No Abnormal Bleeding or Bruising
Yes No Prolonged Bleeding or Transfusion
Yes No High or Low Blood Pressure

Yes No Cancer, Tumors, Growths or Cysts
Yes No Steroid Therapy or Chemotherapy
Yes No Diabetes
Yes No Kidney Disease
Yes No Liver Disease
Yes No Hepatitis or Jaundice
Yes No Thyroid Disease
Yes No HIV or AIDS
Yes No Herpes virus or Shingles
Yes No Latex Allergy/Sensitivity
Yes No Birth Defect(s)
Yes No Cleft Lip or Palate
Yes No Cerebral Palsy
Yes No Down Syndrome

Yes No Tuberculosis or TB Exposure
Yes No Frequent Diarrhea or Vomiting
Yes No Ear, Eye, Nose Throat Trouble
Yes No Sinus Problems or Drainage
Yes No Hearing or Vision Impairment
Yes No Epilepsy/ Convulsions/Seizures
Date of Last Seizure_____
Yes No Problems with anesthesia
Yes No Mumps/Measles/Chickenpox
Yes No Scarlet Fever/High Fever
Yes No Stomach Ulcers
Yes No Pregnant
Yes No Other_____

Dental History:

Last visit to a Dentist (Date):_____Dentist's Name:_____
Has your child had any history of the following **habits**: (Check ALL that apply):
❑THUMBSUCKING ❑FINGERSUCKING ❑LIP BITING ❑NAIL BITING ❑PACIFIER USE ❑EXCESSIVE BOTTLE USE
History of **injuries** to Mouth/Teeth/Head? **YES/NO** If YES, please explain:_____
Purpose of dental visit today:_____
Describe how you believe your child will behave today (Check ALL that apply):
❑FRIENDLY ❑HAPPY ❑TIMID ❑AFRAID ❑RESISTANT

Social History:

Child's First Language: _____ Second Language: _____
Child's Favorite: PET _____ TOY_____ COLOR _____ HOBBY _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medial status.

Parent/Guardian Signature: _____ Relationship to patient: _____ Date: _____

Texas Tooth Fairies Pediatric Dentistry
Pamela R. Singletary, DDS Jeffrey B. Gregerson, DMD
Michelle J. Kim, DDS Sheetal R. Asher, DMD (Board Eligible)
Diplomats of the American Board of Pediatric Dentistry

FAMILY INFORMATION

YOUR CHILD(REN):

How many children do you have in your household? _____
Name(s):

_____ Existing patient? Yes / No
_____ Existing patient? Yes / No
_____ Existing patient? Yes / No
_____ Existing patient? Yes / No
_____ Existing patient? Yes / No
_____ Existing patient? Yes / No

If you are an existing family, is the information for your child(ren) being seen today the same as their sibling's information that we have on file?
CIRCLE ONE: Yes No Not Applicable
If it is the same please proceed to the consent forms.
If no or not applicable, please complete this form.

Primary Home Address:
_____ Apt. #_____
City: _____ Zip: _____
Home Phone: _____

Primary Guardian: _____

How did you hear about our practice?
_____

PARENT INFORMATION:

CIRCLE ONE: Mother/Stepmother/Co-Parent/Guardian

❑Married Name of Spouse: _____
❑Single ❑Divorced
Name: _____
First MI Last
SS#: _____ Date of Birth: _____
Employer: _____Occupation: _____
Mom's Cell: _____ Work Phone: _____
Mom's Email: _____
Home Address (if different from primary):
_____
City: _____ Zip: _____

CIRCLE ONE: Father/Stepfather/Co-Parent/Guardian

❑Married Name of Spouse: _____
❑Single ❑Divorced
Name: _____
First MI Last
SS#: _____ Date of Birth: _____
Employer: _____Occupation: _____
Dad's Cell: _____ Work Phone: _____
Dad's Email: _____
Home Address (if different from primary):
_____
City: _____ Zip: _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____
Insurance Phone#: _____
Insurance Address:
_____
_____
Policy Holder: _____
Relationship to Patient: _____
Employer: _____
D.O.B:_____SS#:_____
ID: _____ Group#:_____
Plan Effective Date: _____

SECONDARY DENTAL INSURANCE (if applicable):

Insurance Company: _____
Insurance Phone#: _____
Insurance Address:
_____
_____
Policy Holder: _____
Relationship to Patient: _____
Employer: _____
D.O.B:_____SS#:_____
ID: _____ Group#:_____
Plan Effective Date: _____

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
Pamela R. Singletary, DDS Jeffrey B. Gregerson, DMD
Michelle J. Kim, DDS Sheetal R. Asher, DMD (Board Eligible)
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CONSENT FOR DENTAL PROCEDURES AND ACKNOWLEDGEMENT FOR RECEIPT OF INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, examination of the teeth, examination of hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, crowns, sealants, extractions, etc. will be performed at a separate appointment after obtaining your permission. No dental treatment will be performed without your knowledge.

State Law requires that we obtain your written informed consent for any treatment given your child as a legal minor.

Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain further.

1. I hereby authorize and direct the Texas Tooth Fairies team of doctors and/or dental auxiliaries of their choice, to perform upon my child, the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms the dental procedures or operations will include:
   A. Cleaning of the teeth and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth
   C. Treatment of diseased or injured teeth with dental restoration (fillings or caps).
   D. Replacement of missing teeth with dental prosthesis.
   E. Removal (extraction) of one or more teeth.
   F. Treatment of malposed (crooked) teeth and/or oral development of growth abnormalities.
   G. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1 ½-3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child that they are going to get a "shot." We have our special way to inform them of this.
   H. Use of behavior management techniques outlined on page 4.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage, or death. I further authorize the Texas Tooth Fairies team of doctors and their team members to perform treatment as may be advisable to preserve the health and life of my child.

I hereby state that I have read and understand this consent and the behavior management techniques on page 4 (if applicable) and that all questions about the procedure or procedures have been answered in a satisfactory manner; I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I chose to terminate it (Termination of agreement must be presented in writing.)

Date: _____ **Time:** _____ **am/pm**

PATIENT NAME(S):_____

Signature of Parent of Guardian: _____

Relationship to Patient: _____ **Witness Signature:** _____

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BEHAVIOR MANAGEMENT TECHNIQUES

t is our intent that all professional care delivered in our dental office be the best possible quality we can provide for each child. Providing a high uality of care can sometimes be made very difficult or even impossible, because of the lack of cooperation of some children. Among the behaviors nat can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it pen long enough to perform the necessary dental treatment and even aggressive or physical resistance to treatment, such as kicking, screaming nd grabbing the dentist's hands or the sharp dental instruments.

ll efforts will be made to obtain the cooperation of the child by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness nd understanding.

here are several behavior management techniques that are used by pediatric dentists to gain the cooperation of children to eliminate disruptive ehavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry ehavior management techniques are as follows:

1. **Tell-show-do**: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstration with instruments on a model or the child's or dentist's finger. Then the procedure is performed on the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive reinforcement**. This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or prize.
3. **Voice Control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important that the abrupt or sudden nature of the command.
4. **Mouth Props**: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth. The item is referred to as a "**pillow**" and simply aids the child in keeping his/her mouth open.
5. **Head Control:** The dentist stabilizes the child's head between the dentist's arm and body. The dental assistant may often assist in stabilizing the child's head and preventing the child from flaring their head while the dentist performs the restorative procedure which is deemed necessary.
6. **Physical Restraint by the Assistant:** The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements. The doctor treating your child may ask you to assist in controlling them as necessary.
7. **Papoose Boards & Pedi-Wraps:** These are restraining devices for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in this device and placed in a reclined dental chair. We refer to these devices as a "**blanket**" or "**tiny surf-board**" so as not to frighten the child. This device will not be used without your being further informed and obtaining your specific approval and consent for such procedures.
8. **Sedation**: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally. The child does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.
9. **General anesthesia**: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given anesthesia without your being further informed and obtaining your specific consent for such procedure.

*I hereby state that I have read and understand this **Behavior Management Techniques Form**, that I have been given the opportunity to ask questions I might have and that **all questions** about the procedures **circled** have been answered in a satisfactory manner.*

BY SIGNING THIS SHEET, I HEREBY GIVE THE TEXAS TOOTH FAIRIES TEAM OF DOCTORS & THEIR ASSISTANTS CONSENT TO USE THESE BEHAVIOR MANAGEMENT TECHNIQUES ON MY CHILD.

PATIENT NAME(s) _____

_____ _____

SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY **DATE**

_____ _____

PRINTED NAME **RELATIONSHIP TO PATIENT(S)**

TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY
Pamela R. Singletary, DDS Jeffrey B. Gregerson, DMD
Michelle J. Kim, DDS Sheetal R. Asher, DMD (Board Eligible)
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FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our front office staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

1. **Payment is due at the time of service.** For your convenience, we will accept Cash, Check, Visa, Master Card, Discover, American Express and Care Credit.
2. **Your insurance is a contract between you and your insurance company.** As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. **We are contracted with most major insurance carriers.** Please verify Dr. Singletary, Dr. Gregerson, Dr. Kim and /or Dr. Asher are listed on your plan if you are concerned about utilizing your "in network benefits" or ask our front office staff for further details.
4. **All dental plans are not the same and do not cover the same services.** In the event your dental plan determines a service to be "not covered" or over what they deem "usual and customary charges"' you will be responsible for this amount.
5. **Insurance companies will not "guarantee payment" for any services**, therefore any estimation given of coverage by your dental plan cannot be guaranteed by our office.
6. **Payment is due upon receipt of statement from our office.** If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore, we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.
7. **Your estimated portion of our fees for scheduled hospital procedures is due when scheduling the surgery date.** Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.
8. **The adult accompanying** the child is responsible for payment for services rendered to a child patient.
9. **We are not a party to divorce decrees.** By signing this form, you agree that you are the sole person responsible to us for your child's bill. You must coordinate and seek payment from any other party you feel shares this obligation.
10. **Missed Appointment(s) Policy – Although, we make every attempt to remind you of your scheduled appointment, it is your responsibility to remember all appointment date(s)/time(s). The doctor has reserved this time, especially for you and your child to meet their dental needs. Cancellations require a 24 hour prior notice, or your account may be assessed a $25 missed appointment fee for routine services and $50.00 for treatment related services.**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Patient Name(s) _____

_____ _____
SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY **DATE**

_____ _____
PRINTED NAME **RELATIONSHIP TO PATIENT(S)**

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION, SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the Texas Tooth Fairies team of doctors to release to hospitals or health care service plans, insurance companies, self-insurers or their representatives, any and all information and records (including x-rays) about my medical history, services rendered or treatment given to my child/children that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization, review or financial audit.

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Dr. Singletary, Dr. Gregerson, Dr. Kim and/or Dr. Asher to submit claims for payment for services to healthcare service plans or insurance companies on my behalf and in my name and I assign to Dr. Singletary, Dr. Gregerson, Dr. Kim and/or Dr. Asher the group's insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for covered services. I authorize and request my insurance company to pay directly to the dentist or dental group, any insurance benefits otherwise payable to me. This authorization shall remain in effect until written notice is given by either party. I know I have a right to receive a copy of this authorization if requested. I also understand that although the Texas Tooth Fairies team of doctors strive to give the most accurate insurance information possible with regards to my plan, **it is ultimately my responsibility as the parent/insured/subscriber to know and understand my benefits, limitations and exclusions of my individual policy.**

I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I agree to be responsible for payment of all services rendered on behalf of my dependent(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that payment of a calculated % is due at the time treatment is rendered and that my dental insurance carrier may pay less than the actual bill for service.

(NOTE: WE ARE FILING YOUR INSURANCE AS A COURTESY. FOR US TO CONTINUE THIS SERVICE, WE ASK THAT ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY BE PAID BY YOU AT THE TIME YOU RECEIVE OUR STATEMENT).

Patient Name(s) _____

_____ _____
SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY **DATE**

_____ _____
PRINTED NAME **RELATIONSHIP TO PATIENT(S)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____(Parent Name-PRINT), have received a copy of this office's Notice of Privacy Practices, and hereby authorize use and disclosure of my child's patient information as described therein, for the following patient(s).

PATIENT NAME(s) _____

_____ _____ _____
SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT(S)** **DATE**

You May Refuse to Sign This Acknowledgement and Authorization

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 / Communication Barriers / Emergency Situation / Other
Office Employee Initial:_____ Date:_____

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AUTHORIZATION FOR USE AND DISCLOSURE TO INDIVIDUAL(S) OTHER THAN PARENT OR GUARDIAN

The following people are allowed to act on my behalf in concern to my child(ren):

_____ _____
Individual's Name (Print) Relationship to patient(s)

_____ _____
Individual's Name (Print) Relationship to patient(s)

_____ _____
Individual's Name (Print) Relationship to patient(s)

I authorize the above listed individuals to do or receive the following:

- Bring my child(ren) to appointments

- Authorize treatment/services for my child(ren)

- Obtain any dental or medical information about my child(ren)

- Give medical information about my child(ren)

- Receive information about appointments for my child(ren)

- Make appointments for my child(ren)

- Give insurance and/or demographic updates about my child(ren)

I, _____ (Parent Name-PRINT), hereby authorize the use and disclosure of the patient information as described in the Notice of Privacy Practices, for the items stated above, for the following patient(s).

Patient Name(s) _____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at:
3401 El Salido Parkway, Cedar Park, Texas 78613 OR front@secure.texastoothfairies.com

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.
Furthermore, I understand, according to Texas Tooth Fairies Pediatric Dentistry's Financial Policy, payment is due from whoever is accompanying the patient to their appointments at the time of service. If I do not intend on the above individuals to make payment on my behalf I will secure or make payment to the office before my child(ren)'s appointment.

_____ _____ _____
SIGNATURE OF PARENT, GUARDIAN OR RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT(S)** **DATE**