Dr. Richard Byrd & Associates
ORTHODONTICS

Patient Information

Date:____/____/____

Patient Name: _____ Mr/Mrs/Ms: _____
Preferred Name: _____ Sex: _____ Martial Status: __S__M__D__W__P
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone : (_____)_____ Cell Phone : (_____)_____
Best Contact Number: Home Cell
Date Of Birth : _____/_____/_____ SSN : _____-_____-_____
Employer: _____ Work Phone: (_____)_____
Email Address: _____
Emergency Contact: _____ Phone: (_____)_____

Information of person responsible for payment (If different from patient):
Name: _____ Relationship to patient:_____
SSN: _____-_____-_____ Date Of Birth : _____/_____/_____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone : (_____)_____ Cell Phone : (_____)_____
Employer: _____ Work 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: _____

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 Dr. Richard Byrd & Associates. 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:** _____

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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 you present or past:

Abnormal/excessive bleeding	Diabetes	Low Blood Pressure
Anemia	Epilepsy	Mitral Valve Prolapse
Arthritis	Heart Murmur	Open Heart Surgery Pacemaker
Artificial Joints	Heart Trouble	Pacemaker
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 you take blood thinners or aspirin daily?_____ Are you nursing or pregnant?_____

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

Any history of bisphosphonate use? IE. 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:_____

_____

Doctors signature:_____

Patient/ Parent/ Guardian Signature: _____**Date:** _____

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ORTHODONTICS

Patient Information

Dental Information **Patient Name:**_____

What is your primary concern for todays visit?

_____

Date of your last dental visit? _____ Name of Dentist? _____

Do you have any broken teeth or teeth causing discomfort? _____

Have you ever had an unpleasant dental experience, if yes please explain? _____

_____

Do your gums bleed easily? _____ If yes when? _____

Do you have any discomfort in your jaw? _____ Do you clinch or grind your teeth? _____

Do you smoke or use tobacco products?_____ Have you ever had orthodontic treatment?_____

Have you ever used a product to whiten your teeth?_____ If yes, when and what product?_____

Do you like your smile? _____ List any changes to your smile you would like to change: _____

_____

Consent:

•All children under 18 must be accompanied by a parent or legal guardian for their appointments. This includes new patient appointments (consults), six-month recall cleaning appointments, restorative appointments, and all orthodontic appointments. It is state law that a parent or legal guardian be present. If your child is brought by any other person they will be asked to reschedule. Further more, due to HIPPA regulations (confidentiality laws), we cannot discuss treatment with anyone other than a parent or legal guardian. Once patient turns 18 years of age we are no longer obligated to discuss treatment or account information with anyone but the patient.

I consent to the disclosure of patient records and or treatment information to the following persons who are involved in the patients care or payment for that care.

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:** _____

Dr. Richard Byrd & Associates
ORTHODONTICS & PEDIATRIC DENTISTRY

9221 Forest Hill Ave • Richmond • VA 23235

2929 Polo Parkway • Midlothian • VA 23113

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) - Patient may be present if diarrhea is not illness related, I.E. caused by antibiotics or food sensitivity
- **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 _____

Dr. Richard Byrd & Associates

ORTHODONTICS

And Pediatric Dentistry

PACIENT 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:

_____ _____

Name Relationship

_____ _____

Name Relationship

Print patients full name _____

Signature _____ Date_____

Relationship to Patient _____

Dr. Richard Byrd & Associates

ORTHODONTICS

And Pediatric Dentistry

Pediatric Dentistry Informed Consent

Patient Name:_____ 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 under going 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 (silver amalgam or 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.

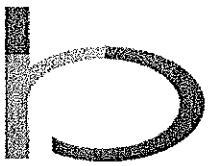
Every reasonable effort will be made to ensure that your child's dental condition is treated properly although it is not possible to guarantee results.

☐ **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 Signature Date



Dr. Richard Byrd & Associates

ORTHODONTICS & PEDIATRIC DENTISTRY

Patient Referral

Thank you for choosing *Dr. Lindsey North* of Dr. Richard Byrd & Associates. Our goal is to provide the very best treatment at the very best price. We encourage you to ask questions and we look forward to serving you. Our patients and referring doctors love to tell others about us, so please take a moment to tell us whom we need to thank!

Patient Name: _____ Date: _____

Patient's Dentist: _____ Location (City): _____

How did you learn about our practice? Please select ALL that apply.

☐ Dentist/ Doctor Referral Name:_____

☐ Family/ Friend Referral Name:_____

☐ Staff Member Referral Name:_____

☐ Our Website (drBYRDdds.com)

☐ Internet Search (a basic search for "Pediatric Dentist")

☐ HealthGrades Report

☐ Facebook (Dr. Richard L. Byrd & Associates Forest Hill)

☐ Insurance Company Referral

☐ I saw the Dr. Byrd ad panel at Chesterfield Town Center

☐ Angie's List, Better Business Bureau or Yelp search/reviews

☐ Other: _____