River Falls
PEDIATRIC DENTISTRY

The following information and history are necessary for the adequate treatment of your child. ***Thank you for completing all information in full.***

SOCIAL HISTORY

Patient's Full Name_____Preferred_____Age_____Sex_____
Race_____DOB_____Place of Birth_____School_____
Patient's SS#_____-_____-_____ Name and type of child's Pet_____ Favorite Interest/hobby_____
How do you expect your child to react to his/her visit today? ____Excellent____Good____Fair____Poor____Not sure
The Parent or Guardian that brings the child is responsible for the account.
Child lives with ____Both Parents ____Mother____ Father ____Stepmother ____ Stepfather ____ Grandparent ____Other: _____
Patient's Address_____City/State_____Zip_____
Father's Full name_____DOB_____SS#_____
His Address_____CityState_____Zip _____
Father's Home Phone_____Cell Phone_____Work Phone_____
Where Employed_____Address_____
Mother's Full Name_____DOB_____SS#_____
Her Address_____City/State_____Zip_____
Mother's Home Phone_____Cell Phone_____Work Phone_____
Where Employed_____Address_____
*Other Children in the family? Names and Ages*_____
How did you hear about us?_____ **Have you seen our Ad in Upstate Parent Magazine?**_____
Reason for bringing your child to the dentist?_____

INSURANCE INFORMATION:

Child is insured by:____Mom ____Dad ____Self ____Medicaid (Medicaid number)_____ Other_____
Insured Person's full name_____DOB_____Insured' s SSC#_____
Insurance Company Name/Address:_____City/State/Zip_____
Insurance ID#_____Group #_____Ins. Company phone number_____

EMERGENCY INFORMATION:

NAME:_____Phone_____Relationship to patient_____

Medical History:

Child's Physician_____Address_____Phone_____
Condition of Child's General Health_____Year of last physical_____

__ Yes __ No Were there any problems during pregnancy or birth of your child?_____
__ Yes __ No Are your child's immunizations up to date? If no, explain_____
__ Yes __ No Is your child allergic to any medications or foods? If yes, what?_____
__ Yes __ No Is your child taking any medications now? If yes , what?_____
__ Yes __ No Have you ever been told by a physician that your child requires antibiotics prior to dental treatment?_____
__ Yes __ No Has your child ever been hospitalized or had an operation? If yes, explain_____
__ Yes __ No Has your child received medical treatment within the last 6 months? If yes, explain_____
__ Yes __ No Does your child have any physical or mental disabilities? If yes, explain_____
__ Yes __ No Does your child have any hearing, sight, speech, or learning problems? If yes, explain_____

Please check any that pertain to your child (explain if applicable)

__ Heart/Cardiovascular	__ Cerebral Palsy	__ Hepatitis	__ Diabetes
__ Mental/Emotional Disorder	__ Rheumatic Fever	__ Asthma	__ Tuberculosis
__ Liver/Kidney Problem	__ Bleeding Disorder	__ Allergies	__ Transfusion
__ Nervous System Problem	__ Sickle Cell Anemia	__ Epilepsy	__ HIV/AIDS

__ Other Explain:_____

DENTAL HISTORY

__Yes __No Is this your childs first dental visit? If no, name of previous Dentist_____
__ Yes __No Are there any hereditary dental problems in the family (missing, extra teeth?),_____
__ Yes __No Has your child or any family member experienced and unfavorable reaction from previous dental treatment?_____
__ Yes __No Has your child ever received injuries to the head, mouth, jaws or teeth? _____
__ Yes __No Does your child have a thumb, finger or pacifier habit?_____
__ Yes __No Does your child take fluoride supplements_____Do you have a private well or public/city water?_____
Was your child breast or bottle fed?_____To what age?_____

I agree to diagnostic procedures and dental treatments found necessary and desirable by Dr. Chana Tocharoen, for the patient named above.
I do also authorize and request the administration of such anesthesia and/or sedatives as may be deemed advisable by the above named doctor.
I am aware that I will be informed of all services before any treatment is rendered to my child. I will accept responsibility for this account should named responsible party fail or insurance benefit be denied.

DATE: : _____SIGNATURE: _____

Chana Tocharoen, DMD - 505 Squires Pointe, Duncan, SC 29334 - 864.433.6888 – (F)864.433.6889

Authorization- Compound Treatment & Social Media

This authorization form permits ***River Falls Pediatric Dentistry*** to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Patients Name _____ Birth Date _____
Patients Name _____ Birth Date _____
Patients Name _____ Birth Date _____
Patients Name _____ Birth Date _____
Patients Name _____ Birth Date _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voice mail #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Voice mail Business # _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Unencrypted email address: _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Text Messages #_____	☐ Appointment time ☐ Other _____
Any treating facility to receive PHI by unencrypted email	☐ Unencrypted treatment information with minimal identifiers
Employer _____ School _____	☐ Appointment or absentee information ☐ Return to work or school information
Parent or Spouse & Relationship Name_____ Relationship- _____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ Medical information- please list _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ Medical information- please list _____ _____
General or Social Media viewing	☐ Photos ☐ Other _____ ☐ Other _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or

_____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

_____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient

River Falls
PEDIATRIC DENTISTRY

FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our front office staff is trained to inform you of the financial policies of this office. Your signature below indicates that you understand and accept our policy. **Payment is due at the time of service**. We accept all major credit cards, cash or checks. We consider the account responsible party the person who signs the financial policy.

Dental Insurance
Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to this contract. We will bill your primary insurance only as a courtesy to you. Although we may *estimate* what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower payment from the insurance company. You will need to supply our office with a copy of your dental insurance ID card. After 45 days from the date of service PAYMENT IS EXPECTED IN FULL FROM YOU.

Sedations
A reservation fee of $100.00 is required to make a sedation visit appointment. This fee will be applied to your portion of the bill that day. If the appointment is missed or if the patient is excessively late, the $100.00 fee will be kept as a missed sedation fee charge.

Medicaid
Our office accepts South Carolina Medicaid **ONLY**. We will bill Medicaid for the covered services, but you are responsible for any charges not covered at the time of service. If the recipient is not eligible at the time of service, you will be responsible for all charges incurred. You will need to supply our front office with a copy of your Medicaid card. ****ALL SERVICES ARE NOT COVERED BY MEDICAID**** If a sedation appointment is missed or if the patient is excessively late, you will be asked to transfer their records to another dentist.

Self Pay (NO INSURANCE COVERAGE)
All fees must be paid at the time of service. We offer a 5% discount if you pay by cash/check at the time of service and a 3% discount if you pay by credit/debit card.

Missed Appointments
In order to allow the best possible care for our patients, we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a **24 hour notice is required or a $25.00 - $45.00** charge will apply. That fee will have to be paid to schedule a new appointment. Patients with two missed appointments will be asked to transfer their records to another dentist.

A **finance charge** will be imposed on each item of your account, which has not been paid within thirty (30) days from the time the item was posted to your account. This finance charge will be computed at the rate of 1 ½ percent per month. The minimum finance charge is $.50.

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to all lawyers' fees, which we incur, plus all court cost.

You will need to complete a **Records Release** form (which can be obtained from our office) if you wish to have copies of your records sent to another doctor or organization. If your account has a past due balance, records cannot be transferred until the balance is paid **in full**. Upon transfer of records, you authorize us to include all relevant information, including your payment history. After such request we have up to fifteen (15) days to send your records.

_____ _____

Signature Date

Dr. Chana Tocharoen, DMD - 505 Squires Point, Duncan, SC 29334 - 864.433.6888 (F) 864.433.6889

River Falls
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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices for the above Office.

_____ _____

Signature: Patient's Name/Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- Document presented to patient, but patient refused to sign acknowledgement.
- Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to give the Notice, and get any acknowledgement will be handled as soon as possible.
- Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- The documentation was mailed to the patient but never returned to us.
- Other: _____

_____

_____ _____

Employee preparing document (Print) Date

_____

Employee Signature

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