

# Welcome to Evergreen Pediatric Dentistry!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your child's dental health.

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name of child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Preferred Name (Nickname) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

Name of person accompanying child to 1st visit **-MUST BE PARENT OR LEGAL GUARDIAN** \_\_\_\_\_

Are child's parents: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Never been married \_\_\_

With whom does the child reside? \_\_\_\_\_

Primary contact person (for scheduling and billing)? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## FAMILY INFORMATION

### Mother's/Guardian's Information

Name \_\_\_\_\_  
Date of Birth (required) \_\_\_\_\_  
Social Security # (required) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_  
Cell # \_\_\_\_\_  
E-mail \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_

### Father's/Guardian's Information

Name \_\_\_\_\_  
Date of Birth (required) \_\_\_\_\_  
Social Security # (required) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_  
Cell # \_\_\_\_\_  
E-mail \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_

In the event of an emergency (if parent/s became incapacitated), whom should we contact?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

***PERSON ACCOMPANYING CHILD IS EXPECTED TO MAKE PAYMENT AT TIME OF SERVICE (INCLUDING ESTIMATES)***

## INSURANCE

### PRIMARY

Dental Insurance \_\_\_\_\_  
Subscriber \_\_\_\_\_  
Dental ID # \_\_\_\_\_  
Group # \_\_\_\_\_  
Dental Insurance Phone # \_\_\_\_\_

### SECONDARY

Dental Insurance \_\_\_\_\_  
Subscriber \_\_\_\_\_  
Dental ID # \_\_\_\_\_  
Group # \_\_\_\_\_  
Dental Insurance Phone # \_\_\_\_\_

***YOU ARE RESPONSIBLE FOR YOUR OWN DENTAL COVERAGE AND BENEFITS. PLEASE ASK IF WE ARE IN YOUR INSURANCE NETWORK.***

## DENTAL HISTORY

**YOU ARE RESPONSIBLE FOR THE TRANSFER OF ANY PREVIOUS DENTAL RECORDS (INCLUDING X-RAYS) FOR YOUR CHILD. IF WE DO NOT HAVE RECORDS AT THE TIME OF YOUR VISIT WE WILL TAKE NEW ONES.**

Date of last dental visit \_\_\_\_\_ Previous Dentist \_\_\_\_\_  
Procedures done at last visit \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_

Has your child had any injuries to mouth, teeth, head, or any dental complaints, (if so please explain)?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child brush daily? \_\_\_\_\_ Floss daily? \_\_\_\_\_ Take fluoride in any form? \_\_\_\_\_

Does your child have any mouth habits such as thumb/finger sucking, mouth breathing, pacifier, sleeping with bottle/sippy cup, grinding?  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any particular concerns, issues or specific questions that you would like us to address? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Results \_\_\_\_\_

Is your child under the care of physician at this time for anything other than routine exams? If so, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever had any kind of surgery? If yes, Please explain why, where and when. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child taking any medications? If yes, please list and explain why.  
\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies your child has and reactions they have experienced. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have a history of any of the following?

A.I.D.S./H.I.V.	Anemia	Aspergers Syndrome	Asthma	Autism
Bladder Problems	Blindness	Cancer	Cerebral Palsy	Chicken Pox
Convulsions	Developmental Delays	Diabetes	Downs Syndrome	
Drug/Alcohol Abuse	Drug Allergies	Emotional Issues	Epilepsy/Seizures	Fainting
Head Injuries	Heart Murmur/Disease	Hepatitis	Kidney Disease	Latex Allergy
Liver Disease	Measles	Mononucleosis	Mumps	Rheumatic Fever
Sinus Problems	Speech Delay	Thyroid Disease	Tuberculosis	Other

## CONSENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist of any changes regarding my child's health. I certify that I am the parent or legal guardian of \_\_\_\_\_ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## **EVERGREEN PEDIATRIC DENTISTRY POLICIES**

We are committed to providing you with the best quality of dental care and excellence in customer service. To achieve these goals, we greatly depend on your cooperation and your understanding of our appointment and payment policies. Thank you for choosing us and for taking time to carefully review the following:

### **Appointments**

Your appointment time is reserved especially for you. We respect your busy schedule and make every effort to see you on time. Please help us achieve this goal by being punctual for your visit.

A minimum of 24 hours notice is required if you are unable to keep your appointment. Repeated cancellations or failure to come to your scheduled appointments may result in a \$50 charge and/ or refusal of further care in our office. Thank you in advance for your cooperation. \_\_\_\_\_ (initial)

### **Financial Issues**

#### **Families with no dental insurance:**

If you are not insured, full payment for services rendered is expected the day of the appointment. We accept cash, personal checks, VISA, MasterCard or we can help you make financial arrangements through CareCredit. We apply a \$25 charge for returned checks. \_\_\_\_\_ (initial)

#### **Families with dental insurance:**

If you are insured, as a courtesy to you, we will gladly submit your insurance claims on your behalf. However, we expect and appreciate payment of any deductible and/or estimated charges not covered by your insurance at the time of each visit. We accept cash, personal checks, VISA, MasterCard or we can help you make financial arrangements through CareCredit. If for any reason your insurance does not pay, please be advised that you are responsible for the unpaid charges. This agreement shall not be amended orally. Please provide us with as much information about your plan(s) as possible prior to your first appointment. This will assist us in preparing a rough estimate of your anticipated out of pocket expenses before beginning treatment. We apply a \$25 charge for returned checks. \_\_\_\_\_ (initial)

### **Authorization and Release**

The parent or guardian who is signing this form is responsible for all account transactions and balances. All outstanding balances shall accrue interest at the rate of 12% per year (interest is compounded).

If insurance is involved: I authorize payment directly to Dr. Susan Kim, DDS for insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize Evergreen Pediatric Dentistry to use my child's healthcare information in the submission of all insurance claims in order to obtain payment for services and predeterminations. I authorize all credit inquiries deemed necessary in connection with my account.

*I understand and accept all the above Appointment and Payment Policies.*

Your name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Patient's name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Acknowledgement of Receipt of  
Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Evergreen Pediatric Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Evergreen Pediatric Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

<b>ADDITIONAL DISCLOSURE AUTHORIZATION</b>		
<i>In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)</i>		
<b>Parent only</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OR</b>		
<b>Any Member of the immediate family: (Parent, Aunt, Uncle)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Any Member of my extended family: (Grandparents, etc.)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Other:</b> _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Name of patient (please print):</b> _____		
<b>Parent or Guardian's Name (Please Print):</b> _____		
<b>Parent or Guardian's Signature:</b> _____		
<b>Representative's Telephone Number:</b> _____ <b>Date:</b> _____		

**OFFICE USE ONLY BELOW THIS LINE**

<b>Acknowledgement Not Obtained</b>			
<b>Provided Prior to Treatment?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Date Statement Provided:</b> _____
<b>Reason for not obtaining patient signature</b>	<input type="checkbox"/>	<b>Needed more time to review Statement</b>	
	<input type="checkbox"/>	<b>Wanted to consult another person before signing</b>	
	<input type="checkbox"/>	<b>Physically unable to sign</b>	
	<input type="checkbox"/>	<b>No reason offered</b>	
	<input type="checkbox"/>	<b>Other:</b>	

## STATEMENT OF PRIVACY PRACTICES

### Evergreen Pediatric Dentistry

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your obligations and your rights.

#### *Protecting Your Personal Healthcare Information*

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

#### *Collecting Protected Health Information (PHI)*

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

#### *Disclosure of your Protected Health Information*

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

#### *Your Rights as our Patient*

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.