

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 _____

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

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Father's/Guardian's Information

Name _____

Date of Birth (required) _____

Social Security # (required) _____

Address _____

City _____ Zip Code _____

Home # _____ Work # _____

Cell # _____

E-mail _____

Occupation _____

Employer _____

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 # _____

Is your child covered by DSHS/Molina/Medicaid/Medical Coupon? _____

(If yes, coupon MUST be presented at EVERY visit.)

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. Jimmy Yun, DDS and Dr. Susan Kim, DDS of 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 _____

Evergreen Pediatric Dentistry

12303 NE 130th Lane, Suite 340

Kirkland, Washington 98034

426-814-3196

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 that are 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 to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SPOUSE ONLY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
OTHER (PLEASE SPECIFY):	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained					
PROVIDED PRIOR TO TREATMENT?	<input type="checkbox"/>	<u>YES</u>	<input type="checkbox"/>	<u>NO</u>	
DATE PROVIDED:					
REASON FOR DENIAL:	<input type="checkbox"/>	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.			
	<input type="checkbox"/>	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.			
	<input type="checkbox"/>	UNABLE TO SIGN.			
	<input type="checkbox"/>	REASON NOT GIVEN.			
	<input type="checkbox"/>	OTHER (EXPLAIN):			

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect 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 to anyone – even family members – without your written consent. 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 of 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 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.

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 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.

Please ask if you have any questions about your privacy rights or the protection of your health information.