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) _____

HomeAddress_____
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? _____

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FAMILY INFORMATION

Mother's/Guardian's Information	Father's/Guardian's Information
Name _____	Name _____
Date of Birth (required) _____	Date of Birth (required) _____
Social Security # (required) _____	Social Security # (required) _____
Address _____	Address _____
City _____ Zip Code _____	City _____ Zip Code _____
Home # _____ Work # _____	Home # _____Work # _____
Cell # _____	Cell # _____
E-mail _____	E-mail _____
Occupation _____	Occupation _____
Employer _____	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	SECONDARY
Dental Insurance _____	Dental Insurance _____
Subscriber _____	Subscriber _____
Dental ID # _____	Dental ID # _____
Group # _____	Group # _____
Dental Insurance Phone # _____	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 you 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 _____

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.

ADDITIONAL DISCLOSURE AUTHORIZATION		
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.)		
Parent only	**☐ YES**	**☐ NO**
OR		
Any Member of the immediate family: (Parent, Aunt, Uncle)	**☐ YES**	**☐ NO**
Any Member of my extended family: (Grandparents, etc.)	**☐ YES**	**☐ NO**
Other: _____	**☐ YES**	**☐ NO**
Name of patient (please print): _____		
Parent or Guardian's Name (Please Print): _____		
Parent or Guardian's Signature:_____		
Representative's Telephone Number: _____Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:_____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Evergreen Pediatric Dentistry
12910 Totem Lake Blvd NE Suite 103 * Kirkland, Washington * 98034 * 425-814-3196

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 our 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.

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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 48 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 $75 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 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 _____