Welcome to The Kids' Dentist
NEW PATIENT FORMS

TODAY'S DATE ___________________________

CHILD'S FIRST NAME ___________________________________ MI _________ LAST NAME ____

PREFERRED NAME: ____

MALE ☐ FEMALE ☐ DATE OF BIRTH __________-__________-__________ AGE ________________________

ADDRESS____

CITY____ STATE _______________ ZIP _________________________

PLEASE LIST IN ORDER THE BEST NUMBERS TO REACH YOU REGARDING YOUR CHILD'S DENTAL APPOINTMENTS:

PHONE #1 ______________-______________-_______________ ☐ CELL ☐ HOME ☐ WORK

PHONE #2 ______________-______________-_______________ ☐ CELL ☐ HOME ☐ WORK

PHONE #3 ______________-______________-_______________ ☐ CELL ☐ HOME ☐ WORK

CAN YOU RECEIVE TEXT MESSAGES ON YOUR CELL PHONE? ☐ YES ☐ NO

EMAIL ____

HOW DID YOU HEAR ABOUT US? ____

FATHER'S/GUARDIAN'S FULL NAME ____ DOB ___________________

MOTHER'S/GUARDIAN'S FULL NAME ____ DOB ___________________

PERSON RESPONSIBLE FOR MAKING DENTAL APPOINTMENTS AND FINANCIAL ARRANGEMENTS ____

OTHER CHILDREN IN FAMILY (NAMES AND AGES) ____

AUTHORIZATION

I authorize The Kids' Dentist to release any and all medical or dental information for evaluation, treatment, and any anticipated care. I understand that I am responsible for any and all charges (including collection fees). I understand that the estimated patient portion is due at the time that services are rendered, unless other arrangements have been made for payment. I also understand that any treatment estimate that is given to me is done in good faith and I understand that my insurance may not pay the amounts estimated by The Kids' Dentist. I understand that I am responsible for knowledge of my insurance program and the limitations of it. I have read this authorization and understand its contents.

SIGNATURE ____ DATE _____________________

RELATIONSHIP TO PATIENT ____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO If yes, please fill out the section below

PRIMARY SUBSCRIBER'S NAME ______________________________

DATE OF BIRTH ______________________________ SS# ______________________________

ID NUMBER (IF YOUR INSURANCE DOES NOT USE SS#) ______________________________

EMPLOYER ______________________________ WORK NUMBER ______________________________

DENTAL INSURANCE NAME AND CLAIMS ADDRESS ______________________________

____

____

GROUP NUMBER ______________________________ INSURANCE PHONE NUMBER ______________________________

EFFECTIVE DATE ______________________________

DO YOU HAVE SECONDARY DENTAL INSURANCE? ☐ YES ☐ NO If yes, please fill out the section below

SECONDARY SUBSCRIBER'S NAME ______________________________

DATE OF BIRTH ______________________________ SS# ______________________________

ID NUMBER (IF YOUR INSURANCE DOES NOT USE SS#) ______________________________

EMPLOYER ______________________________ WORK NUMBER ______________________________

DENTAL INSURANCE NAME AND CLAIMS ADDRESS ______________________________

____

____

GROUP NUMBER ______________________________ INSURANCE PHONE NUMBER ______________________________

EFFECTIVE DATE ______________________________

***** PLEASE KEEP IN MIND THAT TO BILL YOUR INSURANCE CORRECTLY WE NEED ACCURATE, UP TO DATE INFORMATION. PLEASE HAVE YOUR CARD AVAILABLE SO WE CAN MAKE A COPY FOR YOUR CHILD'S FILE. *****

AUTHORIZATION

I UNDERSTAND THAT I AM RESPONSIBLE FOR KNOWING MY INSURANCE PLAN PROVISIONS AND LIMITATIONS AND THAT ANY INFORMATION I GIVE WILL BE USED TO BILL MY INSURANCE FOR TREATMENT RENDERED IN THE OFFICE. I UNDERSTAND THAT THE KIDS' DENTIST MAY NOT BE A PREFERRED PROVIDER WITH MY INSURANCE. I ALSO UNDERSTAND THAT EVEN IF I HAVE INSURANCE, THE KIDS' DENTIST MAY ASK FOR THE PORTION THAT MY INSURANCE DOES NOT COVER AT THE TIME SERVICES ARE RENDERED, AND THAT I AM ULTIMATELY RESPONSIBLE FOR MY ACCOUNT.

SIGNATURE ______________________________ DATE ______________________________

Rev 02/28/2017

Health History Form

GENERAL INFORMATION

Patient Name ____ DOB __________________ Weight _____________
Parent/ Guardian filling out form ______________________________ Describe child's temperament_______________________________
Is your child adopted? YES NO Do they know? YES NO Is this a foster child? YES NO

DENTAL INFORMATION

NEW PATIENTS ONLY: Name of previous dentist ____ Phone # ________________
Date of last dental exam____________________________ Cleaning _______________________ X-rays_____________________
Is there a particular concern you would like examined today? ____
Has your child had any negative dental or medical experiences? ____
Is your child currently taking fluoride drops/tablets? YES NO If yes, how much/when_____________________________________
Does your child drink water from the tap? YES NO Bottled Water? YES NO

ALL PATIENTS: Does your child have, or have they had any of the following? Please check all that apply

- TMJ, painful or locking jaw
- Nursing or bottle feeding at night
- Thumb sucking/ pacifier
- Grinding or clenching of teeth
- Tongue thrust
- Mouth breather, nail biting

MEDICAL INFORMATION

Child's Physician ____ Phone # ____
Date of last exam _______________________________ Are your child's immunizations up to date? ______________________________
FEMALE PATIENTS: Is there any chance you might be pregnant? YES NO Are you taking birth control pills? YES NO
Has your child ever been hospitalized? YES NO Injuries/ surgeries_______________________________________ Date__________
Does your child have any allergies or reactions (aspirin/pain medications, food, antibiotics, latex, preservatives/flavorings, etc.)? YES NO
____
Any medication taken on a regular basis (prescription, over the counter, vitamins, etc.)? _______________________________________

Has your child ever had or does he/she now have any of the following diseases/conditions? Please check all that apply.

- Heart disease, murmurs, or rheumatic fever
- Low or high blood pressure
- Kidneys, Endocrine, Liver (hepatitis), GI, Thyroid
- Cancer, tumors, other growths
  If yes, radiation or chemotherapy Date _____________
- Epilepsy, seizures, or fainting
- Congenital birth defects _________________________
- Diabetes, arthritis
- Asthma If yes, treatment ________________________
- Other breathing problems/ diseases of lung (TB)
- Bleeding problems or diseases of the blood
- Blood transfusions? Date _______________________
- Sinusitis, seasonal allergies
- Cold sore, canker sores
- Venereal or other serious infections
- Problems with vision or hearing
- Fever, sore throat/tonsils, ear aches/infections
- Frequent/recurrent headaches or migraines
- Dietary restrictions________________________________
- Childhood diseases________________________________
- Immunological problems or diseases (Leukemia, AIDS/HIV)
- Tobacco use (any form)
- Chemical dependencies
- Emotional problems
- Learning or behavioral problems *
- Developmental delay/ mental challenges *
- Autism spectrum or sensory issues *

*** If you answered yes to the last 3 questions, please fill out the Supplemental Health History form**

Are there any other conditions or anything else we should know about your child? ____

____
Parent Signature Date Provider Signature Date

The Kids' Dentist
364 Renton Center Way SW, Suite 62, Renton, WA 98057
P: (425) 255-5532 F: (425) 255-1658

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 The Kids' Dentist. 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.

The Kids' Dentist 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 state 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 child's Protected Healthcare Information to the person(s) identified below (other than me). (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual questions, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

My Spouse	❏ **YES**	❏ **NO**
Any member of my immediate family (Spouse, Children, Children's Spouses)	❏ **YES**	❏ **NO**
Any member of my extended family (Parents, Grandchildren)	❏ **YES**	❏ **NO**
Other:		
Name of Patient:		
Patient Signature (If 18 years or older)		
Parent/ Guardian:		
Parent/ Guardian Signature:	**Date:**	
Representative's Telephone Number:		

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 of Privacy Practices**
		❏	**Wanted to consult another person before signing**
		❏	**Physically unable to sign**
		❏	**No reason offered**
		❏	**Other:**

REVISED 02/27/2017

The Kids Dentist
CONSENT FOR DENTAL TREATMENT

1. State Law requires us to obtain your consent for your child's contemplated dental treatment. Please read this form carefully, and feel free to ask us if we can explain anything more clearly.

2. I hereby authorize Dr. Dansie, and/ or Dr. Lothyan, assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following dental treatment or oral surgery procedures:

Exam, Prophy Cleaning, Fluoride, X-Rays, Extractions, Composite (tooth-colored) Fillings, Stainless Steel Crowns, Pulp (nerve) Therapy, Space Maintainer Placement & Sealants.

Dr. Dansie, and/or Dr. Lothyan, have explained the nature and purpose of the treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, risks, consequences and probable effectiveness of each, as well as prognosis if no treatment is provided.

I am advised that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as the cure. I further authorize Dr. Dansie, or Dr. Lothyan, to perform other dental service(s) that in their judgment are advisable for my child or legal ward, with the exception of (if none, so state):

None

3. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the application of topical fluoride if it is swallowed and children biting or injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, extracted tooth or gauze packing;

injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings). Injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before the treatment to minimize the risk.

I further understand and accept the complications may require additional medical, dental or surgical treatment and may require hospitalization.

Additional risks include:

4. I also authorize Dr. Dansie, and/or Dr. Lothyan to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, or scientific purposes.

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner; and I understand further that I have a right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

Patient's Name(s):	
Parent/Guardian's Name:	
Signature of Parent/Guardian:	
Date:	Time:
Relationship to Patient:	
Witness Signature:	