# PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name:

Address: Address 2:

City, State, Zip:

Home Phone:

Sex: Female Male Birth date:

**Responsible Party:**

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

E-mail: I would like to receive email correspondence

Referred By:

Medicaid ID:

**Primary Insurance/Mom/Dad Information:**

Name of Insured: Relationship to Insured: Self Spouse Child Other

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date: Gender: M__F__

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

**Secondary Insurance/Mom/Dad Information:**

Name of Insured: Relationship to Insured: Self Spouse Child Other

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date: Gender: M__F__

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, Please explain_____

Child's Physician's Name: _____ Phone # _____ Last Visit _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Were there any complications? _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Please describe your child's health: Good Fair Poor

Do you have, or have you had, any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Eye Problems | Yes | No | Psychiatric Care | Yes | No |
| Anaphylaxis | Yes | No | Excessive Bleeding | Yes | No | Radiation Treatments | Yes | No |
| Anemia | Yes | No | Fainting Spells/Dizziness | Yes | No | Renal Dialysis | Yes | No |
| Arthritis/Rheumatism | Yes | No | Frequent Cough | Yes | No | Rheumatic Fever/Scarlet | Yes | No |
| Asthma | Yes | No | Frequent Headaches | Yes | No | Scoliosis | Yes | No |
| Autism | Yes | No | Hay Fever | Yes | No | Sickle Cell Disease | Yes | No |
| Blood Disease | Yes | No | Heart Murmur | Yes | No | Sinus Trouble | Yes | No |
| Bronchitis | Yes | No | Heart Trouble/Disease | Yes | No | Snoring at night | Yes | No |
| Bruise Easily | Yes | No | Hemophilia | Yes | No | Spina Bifida | Yes | No |
| Cancer/Leukemia | Yes | No | Hepatitis A | Yes | No | Stomach/Intestinal | Yes | No |
| Cerebral Palsy | Yes | No | Hepatitis B or C | Yes | No | Syndrome | Yes | No |
| Chemotherapy | Yes | No | Hives or Rash | Yes | No | If yes, what? _____ | | |
| Cleft Lip/Palate | Yes | No | Hypoglycemia | Yes | No | Tetanus | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Irregular Heartbeat | Yes | No | Tonsillitis/.Sore Throat | Yes | No |
| Congenital Heart Disorder | Yes | No | Kidney Problems | Yes | No | Tuberculosis | Yes | No |
| Convulsions/Seizures | Yes | No | Liver Disease | Yes | No | Tumors or Growths | Yes | No |
| Developmentally Delayed | Yes | No | Lung Disease | Yes | No | Whooping Cough | Yes | No |
| Diabetes | Yes | No | Mitral Valve Prolapse | Yes | No | | | |
| Epilepsy | Yes | No | Pain in Jaw Joints | Yes | No | | | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____


## OFFICE POLICY REGARDING SCHEDULED APPOINTMENTS

**Our office has guidelines we feel are essential for the successful and continued treatment of your child. We look forward to providing years of dental care for your child and encourage your cooperation and support.**

**We ask that at least 24 hours notice be given to our office if you must cancel or reschedule an appointment. This will allow us adequate time to schedule another child who may be waiting for dental care. You may be asked to seek care elsewhere after two missed appointments.**

**Please be on time for each appointment. It is our goal to see each child as promptly as possible. However due to emergencies, occasionally you may need to wait a short time. We ask for your patience if this occurs. If you have waited more than 15 minutes, please mention it to our receptionists.**

**Most children do very well on their own. We ask that you encourage your child to be seated in the clinic without you present. This allows us the opportunity to establish a good relationship and effective communication with your child. You will be invited to join your child during the Dentist's examination.**

**Nitrous oxide ("Laughing gas") is a mild relaxant commonly used to relieve anxiety during dental appointments. It is only recommended when our Dentist believes it is in your child's best interest. It is important to all of us that dental visits be as pleasant as possible.**

***Please feel free to ask any questions you may have regarding our policies.***

**I have read and understand the office policies and agree to comply with the guidelines on this page.**

**Name**_____ **Date**_____


# NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide your child. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your child's record or get more information about it by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your child's health information may be used and disclosed, and how you can access that information

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

_____ _____

Parent or legally authorized individual signature Date Time

_____ _____

Print your name Relationship (parent, legal guardian, Personal representative

**Child's Name**_____

This form will be retained in your child's record.

FINANCIAL POLICY

**We ask that the parent bringing in the child pay for all treatment and/or co-insurance amounts at the time of the treatment regardless of custody agreements.**

## We accept the following methods of payments

1. CASH ACCOUNTS : We offer a 5% discount. Payment in full is due on the day of service. Any payment arrangements need to be made with our financial coordinator prior to your appointment date. There is a fee for returned checks.
2. CREDIT CARD : MasterCard, VISA and American Express
3. DSHS Medicaid : with a valid Medicaid I.D. card
4. DENTAL INSURANCE

### A word about dental insurance…

Your policy is a contract between you/your spouse's employer and the insurance company. We are not a party to that contract.

Not all services are covered in all contracts. Some insurance companies select certain services they won't cover. Please explore the scope and limitations of your insurance policy.

You will need to provide us with current and accurate insurance and employment information. Inaccurate information delays claims and can result in additional costs.

If your insurance company does not pay us within 60 days of your appointment, the entire balance is due from you. You then can be reimbursed directly from the insurance company.

We file your claims for you as a courtesy. Our courtesy service includes
1. Filing your claim electronically within 24 hours of your visit for short turn around time.
2. If your claim is unpaid, we will file a second time within 60 days.

**At the time you receive our services, you must pay all estimated fees and deductibles not covered by your insurance plan.**

In the event your account is not paid, and we refer the account to collection, you are responsible for all fees incurred to collect your bill. This includes but is not limited to attorney fees, court costs, collection agency fees and late fees. In addition, you will be asked to seek dental care elsewhere for your child.

I have read and understand the above information. I understand by signing this form, I am financially responsible for my dental account. I understand that where appropriate, Credit Bureau Reports may be obtained.

Signature_____

Your name (please print)_____Date_____

The laws of Washington State shall govern this agreement. In the event of a lawsuit regarding this agreement, the venue shall be proper only in Spokane County, Washington.