



Patient's full Name: _____ Sex: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Mother's (Guardian) Full Name: _____ DOB: _____

Home#: _____ Work #: _____ Cell#: _____

Email: _____

Father's (Guardian) Full Name: _____ DOB: _____

Home#: _____ Work #: _____ Cell#: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Home#: _____ Cell#: _____

Primary Dental Insurance: _____ Subscriber: _____

Relationship to Patient: _____ Employer: _____

Subscriber SS# or ID#: _____ Subscriber DOB: _____

Secondary Dental Insurance: _____ Subscriber: _____

Relationship to Patient: _____ Employer: _____

Subscriber SS# or ID#: _____ Subscriber DOB: _____

Whom may we thank for referring you? _____

(Over)

Medical History

Patient Name: _____

Physician: _____ Phone#: _____

Patient's current weight: _____ Patient's current height: _____

- Y N** Is patient in good health?
- Y N** Is patient under a physician's care? If yes for what? _____
- Y N** Does patient have any history of major illness? If yes when? _____
- Y N** Has patient ever been hospitalized? If yes for what? _____
- Y N** Is patient taking any medications at this time? If yes what? _____
- Y N** Does patient have any allergies or drug sensitivities? If yes please list: _____
- Y N** Has patient had tonsils and/or adenoids removed? If yes when: _____
- Y N** Does patient have tendency to frequent () colds () sore throat () ear infections () sinus congestion () breathing problems?

Check any of the following conditions for which the patient has been treated:

- | | | |
|---------------------|--------------------------|------------------------------|
| () Aids/HIV | () Epilepsy/Seizures | () Nutritional Disorders |
| () Arthritis | () Mental Disorders | () Prolonged Bleeding |
| () Asthma | () Endocrine Disorders | () Rheumatic Fever |
| () Blood Disorders | () Fainting/Dizziness | () Speech/Hearing Disorders |
| () Bone Disorders | () Heart Disorders | () Tonsillitis |
| () Cerebral Palsy | () Hepatitis | () Tuberculosis |
| () Diabetes | () Liver/Kidney Disease | () Other: _____ |

Dental History

Family Dentist: _____ Phone#: _____

- Y N** Has patient had any injuries to face/mouth/or teeth?
- Y N** Has patient ever sucked fingers and or thumb? To what age? _____
- Y N** Does patient have any speech disorders? _____
- Y N** Is patient a mouth breather? While awake? _____ While asleep? _____
- Y N** Does patient have any popping/clicking/or discomfort when opening or closing mouth?
- Y N** Has the patient seen a dentist regularly in the past?
- Y N** Has the patient had any dental treatment in the past?
- Y N** Is your drinking water fluoridated?
- Y N** Is the patient taking any fluoridated supplements (e.g. rinse or gel)?
- Y N** Has the patient ever had an unsuccessful dental appointment?

How often are teeth brushed? _____ Flossed? _____ By whom? _____



Financial Policy and Agreement

Outstanding patient service is our goal

The goal of Dr. McDonald and staff is to make sure that you receive the highest quality dental care and service. One step is to make certain that our financial policies are clear and understood by you.

Insurance – We go the extra mile

If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 45 days. We will take complete care of completing and filing the appropriate claims forms with your insurance company. We will also track your claim and make sure that it is paid in a timely manner. We will follow-up with your insurer when claims are not processed efficiently and attempt to expedite payment. We are also happy to provide your insurance company x-rays or any other information they may require. If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you, your insurer, and your employer.

Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.

Your Payment is Due at Time of Treatment

Fees for treatment are due at the time of treatment after deduction of your good faith estimate of insurance benefits as described above.

Payment Options

Cash Check Visa® MasterCard® CareCredit® *

Patient Responsibility

I acknowledge my responsibility for payment of services received from **A Kids Place Dentistry for Children** in accordance with Dr. McDonald's regular fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part, or none of the charges. I understand that this account becomes delinquent if not paid within 60 days after billing and at that time a late fee of \$20 may be charged until the balance is paid in full.

I also acknowledge that **A Kids Place Dentistry for Children** requires **24 hour notice** to reschedule or cancel any appointments. If I fail to give proper notice, I will be required to pay \$50 to reschedule any future appointments.

Assignment and Release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier.

Patient name: _____ **Date:** _____

Parent or Guardian signature: _____

*On approval of credit, this is a revolving line of credit that can be used for current balances as well as future treatment and carries a very reasonable interest rate.



Pediatric Informed Consent

It is your right as a parent to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child.

Please read this form carefully and ask about anything you do not understand. We are pleased to answer your questions.

I have hereby authorized **A Kids Place Dentistry for Children** to preform upon my child the following dental treatments as discussed and outlined by Dr. McDonald and his staff, including the use of any necessary or advisable diagnostic aids or radiographs (x-rays). Please understand that a verbal consent will be obtained prior to the initiation of all dental procedures, restraint, and/or behavior techniques. No procedures will be initiated until verbal consent is obtained.

- Cleaning of the teeth and application of topical fluoride
- Application of plastic "sealant" to the grooves of the teeth
- Administration of local anesthetic agents (numbing)
- Repair of decayed or injured teeth with dental restorations (fillings or crowns)
- Root canal treatment
- Removal (extraction) of one or more primary (baby) or permanent (adult) teeth
- Space maintenance appliances
- Treatment of diseased or injured oral soft tissue
- Use of physical restraint or behavior modification techniques to safely accomplish the necessary dental procedures. **Restraint and behavior techniques are case specific and will only be used following verbal consent.**
- Other: _____

Treatment options have been explained to me, including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee treatment success due to possibilities of complications.

Risks that are occasionally associated with dental treatment procedures include numbness, swelling, bleeding, soreness, discoloration, nausea, vomiting, hyperventilation, fainting, allergic reaction, and infection. On rare occasion complications may arise that require hospitalization.

I agree to remain within the dental office facility while my child is being treated _____.
Initial

I further understand that this consent will remain in effect until such time that I chose to terminate it.

Patient's name: _____ Date: _____ Time: _____

Signature of parent or legal guardian: _____

Relationship to patient: _____

A Kid's Place - Dentistry for Children

451 Duvall Avenue NE, Suite 140

Renton, Washington 98059

425-228-5437

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 A Kid's Place - Dentistry for Children. 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.

A Kid's Place - Dentistry for Children 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.