Child's Health History

Child's Full Name: _____ **Birthdate:** _____

Nickname/Preferred Name: _____ **Legal Sex:** Male ___ Female ___

Gender Identity: Male ___ Female ___ Transgender ___ Non-Binary ___ Other ___ **# of Children in Family:** _____

Dental History:

Is this your child's first dental visit? Yes ___ No ___ • If No, name of former Dentist: _____ Date of Last Visit: _____

Has your child had any dental fear or unhappy dental experiences? Yes ___ No ___

Has your child had any of the following:

Tooth Pain ___ Tooth Trauma ___ Dental Treatment with Oral Sedation ___

Facial Swelling ___ Cold Sores ___ Dental Treatment with General Anesthesia ___

Does your child have any of the following habits:

Thumb Sucking ___ Pacifier Use ___ Snoring ___ Mouth Breathing at Night ___

Lip Sucking ___ Lip Biting ___ Nail Biting ___

Other (explain) : _____

How often are your child's teeth brushed? 1/day ___ 2/day ___ Other ___ • With Adult Assistance? Yes___ No___

How often are your child's teeth flossed? Never ___ 1/day ___ Other ___ • With Adult Assistance? Yes___ No___

Does your child use any of the following: Fluoride Toothpaste ___ Fluoride Drops/Pills ___ Fluoride Mouthwash ___

Does your child drink tap water? Yes ___ No ___ • Tap Water Source: City Water ___ Well Water ___ Other ___

Medical History:

Name of Child's Physician: _____ Date of Last Visit: _____ Phone: _____

Is your child taking any medications? Yes ___ No ___ If yes, please list: _____

Does your child have any allergies? Yes ___ No ___ If yes, please list: _____

Has your child ever been hospitalized? Yes ___ No ___ If yes, please explain: _____

Has your child had any surgeries? Yes ___ No ___ If yes, please list: _____

Has your child had any history of:

Asthma ___ Autism ___ Bleeding Disorder ___ Chemotherapy/Radiation ___ Speech Difficulty ___

Diabetes ___ ADD/ADHD ___ Heart Problems ___ Developmental Delays ___ Hearing Difficulty ___

Seizure Disorder ___ Down Syndrome ___ Kidney Problems ___ Mental/Emotional Disturbance ___

Liver Problems ___ Cerebral/Spastic Condition ___ Sleep Apnea ___ HIV/AIDS ___ Hepatitis ___

Other ___ If Other, please explain:_____

Parent (guardian) Signature: _____ **Date**: _____

Family Information

Patient name(s): _____

Maternal Figure: ☐ Biological Mother ☐ Adoptive Mother ☐ Stepmother ☐ Legal Guardian ☐ Foster Mother

NAME: _____(married/single) Soc. Sec #_____ Birthdate: _____

Mailing Address: _____ City: _____ State:_____ Zip:_____

Primary Phone #:_____CELL/HOME Secondary Phone #:_____CELL/HOME

Preferred Language: _____ Employer: _____ Occupation: _____

Paternal Figure: ☐ Biological Father ☐ Adoptive Father ☐ Stepfather ☐ Legal Guardian ☐ Foster Father

NAME: _____(married/single) Soc. Sec #_____ Birthdate: _____

Mailing Address: _____ City: _____ State:_____ Zip:_____

Primary Phone #:_____CELL/HOME Secondary Phone #:_____CELL/HOME

Preferred Language: _____ Employer: _____ Occupation: _____

Additional Parental Figure (if applicable): ***Relationship to Patient:*** _____

NAME: _____ Soc. Sec #_____ Birthdate: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____CELL/HOME Secondary Phone #: _____CELL/HOME

Preferred Language: _____ Employer: _____ Occupation: _____

In case of emergency, other than those listed above whom may we contact?

Name: _____ Home #: _____ Cell#: _____

Relationship to patient: _____

As a courtesy to you we will be happy to bill your dental insurance for you, provided you have completed this form.

Please check all that apply:

☐ WA State Medicaid, Provider # _____	☐ No Insurance: Cash Paying
☐ Primary Dental Insurance Subscriber: _____ Insurance Company: _____ Subscriber #: _____ Group #: _____	☐ Secondary Dental Insurance Subscriber: _____ Insurance Company: _____ Subscriber #: _____ Group #: _____

Dr. Ashley has an EXTREMELY Strict No-Show Policy:

We strive to stay on schedule. As a courtesy to our patients, we will gladly reschedule appointments with 24-hour notice. However, if you were to No Show to an appointment or give less than 24-hour notice to reschedule, a $54.00 No Show/Late Cancellation charge will be added to your account. Multiple No Shows/Late Cancellations will result in PERMANENT DISMISSAL of the ENTIRE family. No Exceptions.

I have read the office policy and agree to its terms. I understand that the information that I have given today is correct to the best of my knowledge. I will notify the office of any changes directly related to my child, including but not limited to; change of address, contact numbers, insurance information, etc. I authorize Dr. Ashley and/or dental staff to perform the necessary dental services my child may need. This may include exams, radiographs, cleanings, topical application of fluoride, restorative dentistry, and/or oral surgery. I understand I am financially responsible for non-covered services, as well as any remaining balance after my insurance company has paid.

Parent/Guardian Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Yakima Pediatric Dentistry
3909 Creekside Loop # 140
Yakima, WA 98902

Patient Name(s): _____

My signature confirms that I have been informed of mine and my child's rights to privacy regarding protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my child's treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of Yakima Pediatric Dentistry's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that Yakima Pediatric Dentistry has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*, including the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how mine and my child's private information is used or disclosed to carry out treatment, payment or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Additional Authority Authorization

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of the Protected Healthcare Information to the person(s) identified below.

Parents/Legal Guardians (as listed on BLUE "Patient Information" Form) YES ☐ NO ☐

Any member of the immediate family YES ☐ NO ☐

Other: _____ YES ☐ NO ☐
(Please specify: Name/ Relationship to patient)

Legal Guardian (Print): _____ _____
(Relationship to patient)

Legal Guardian Signature: _____ **Date:** _____

- -

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason(s):

☐ No reason offered ☐ Needed more time to review Statement of Privacy Practices

☐ Emergency Situation ☐ Other: _____

FINANCIAL POLICY

Patient(s) Name: _____

Our mission is to deliver compassionate, quality-centered, and cost-effective dentistry. We strive to stay on schedule. As a courtesy to our patients, we offer a 10-minute late grace period, or we will gladly reschedule appointments with 24-hour notice. Missed appointments or cancellations with less than 24-hour notice will result in a broken appointment charge. Multiple broken appointments will result in dismissal of the family.

Payment for dental treatment is due at the time of treatment.

We offer several different payment options:

1) Cash or check
2) Visa, MasterCard, American Express, or Discover
3) CareCredit financing – If interested, please apply online at https://www.carecredit.com/apply/

MISSED APPOINTMENT FEES, INTEREST FEES, LATE CHARGES, & NSF CHECK FEES

- **I acknowledge that a $54.00 charge will be assessed for a missed appointment or late cancellation (less than 24-hour notice).** I also understand that arriving more than ten minutes late for an appointment may result in a cancellation and possible $54 broken appointment charge.
- **I acknowledge that a late charge of 1.0% per month, at a rate of 12% per year, with a minimum charge of $1.00 per month, will be charged on all unpaid account balances that are 30 days past due.**
- **I acknowledge that a $25 charge will be assessed for any "NSF" checks** (i.e., checks not paid by my bank due to non-sufficient funds or for “stop payment”).
- **I realize that failure to keep my account current in payment will result in this office not being able to provide my family with additional dental services. In the case of this account being sent to a collection agency for a past due balance, I agree to pay all collection agency costs, reasonable attorneys fees, and legal expenses incurred to collect such past due balance.**

AUTHORIZATION, RELEASE, AND ACKNOWLEDGEMENT OF FINANCIAL POLICY

- I authorize your office to release any information related to my family’s dental treatment, including any diagnosis and records or x-rays of any treatment or examination rendered during the period of such dental care, to any third party payors, insurance companies, and/or other health and dental practitioners.

- I authorize and request my insurance company, if any, to pay directly to your office the insurance benefits otherwise payable to me. I understand that your office is providing a courtesy to me by allowing me to assign my insurance benefits to your dental office, and that your office may terminate this courtesy at any time.

- I understand that my dental insurance company and/or my primary responsible party may pay less than the actual bill for services. I agree to be solely responsible for full payment of all services rendered on behalf of my dependents should for any reason my insurance company and/or my primary responsible party fail to pay or pay less than full for such services.

- **I acknowledge that I have reviewed, and I accept Yakima Pediatric Dentistry’s Financial Policy.**

X_____ _____

Signature of Parent/Guardian **Date**

THANK YOU for filling out this form completely and reviewing our office policies. The information you have provided will help us serve your family’s dental care needs more effectively and efficiently. If you have any questions, please ask or contact our office at any time. We are always happy to help!