TANIA TRAN DMD
GROVE STREET FAMILY DENTISTRY
1533 Grove Street • Marysville, WA 98270
(360) 659-3200

Children's Form

Child's name: _____
Preferred Name: _____Birth Date: _____ ☐ Male ☐ Female
Child's home address: _____
Child's home phone number: _____
Other family members seen by us: _____
Whom may we thank for referring you? _____

Parent Information
Name: _____ Birth date: _____
Relationship to child: ☐ Mother ☐ Father ☐ Legal Guardian
Occupation: _____ Employer: _____
Work Phone: _____ Cell Phone: _____ E-mail Address: _____
How do you prefer to be contacted: ☐ phone ☐ email or ☐ text?

Parent Information
Name: _____ Birth date: _____
Relationship to child: ☐ Mother ☐ Father ☐ Legal Guardian
Occupation: _____ Employer: _____
Work Phone: _____ Cell Phone: _____ E-mail Address: _____
How do you prefer to be contacted: ☐ phone ☐ email or ☐ text?

Insurance – Primary
Insurance Company Name: _____ Subscriber name: _____
Relationship to Patient: _____Subscriber DOB: _____
Subscriber SSN/ID: _____ Group Number: _____
Subscriber Employer: _____

Insurance – Secondary (if applicable)
Insurance Company Name: _____ Subscriber name: _____
Relationship to Patient: _____Subscriber DOB: _____
Subscriber SSN/ID: _____ Group Number: _____
Subscriber Employer: _____

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Tania Tran DMD PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Financial Responsibility
If parents do not live together, the parent that accompanies the child to the appointment will be responsible for payment at each visit.

Patient/Guardian Signature: _____
Relationship: _____ Date: _____

Children's Dental & Health History

TANIA TRAN DMD
GROVE STREET FAMILY DENTISTRY

Name: _____

Is this your child's first visit to the dentist? ☐ Yes ☐ No
If not, how long since the last visit? _____ Were x-rays taken? ☐ Yes ☐ No
Why did you bring your child to the dentist today? _____
Has your child had an unfavorable experience in a previous dental or medical office? ☐ Yes ☐ No
If yes, please describe: _____
Have there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No
If yes, please describe: _____
Has an Orthodontist seen your child? ☐ Yes ☐ No. Who is the orthodontist? Dr. _____
Does your child brush daily? ☐ Yes ☐ No Floss daily? ☐ Yes ☐ No
Does your child receive fluoride vitamins, tablets, water, etc.? ☐ Yes ☐ No
Has your child ever had any pain or tenderness in his/her jaw? ☐ Yes ☐ No

Child's Habits *Does your child have any of the following habits?*

☐ Lip sucking/biting	☐ Grind teeth	☐ Nail biting
☐ Thumb/finger sucking	☐ Nursing/bottle habits	☐ Other habits _____

Medical History *Has the child ever had any of the following conditions?*

☐ Asthma	☐ Cancer	☐ Hepatitis
☐ Hemophilia/Blood disorder	☐ Rheumatic Fever	☐ Epilepsy/Convulsions
☐ Tuberculosis	☐ HIV/AIDS	☐ Hearing Impairment
☐ Autism	☐ Liver disorder	☐ Kidney disorder
☐ Gastrointestinal disorder	☐ Diabetes	☐ Congenital heart defect
☐ Anemia	☐ ADD/ADHD	☐ Disabilities

Please describe any other medical problems that your child has: _____
_____
Has your child ever been hospitalized or had surgery? _____
_____
Is your child currently under the care of a physician? ☐ Yes ☐ No
Current physician: _____Phone #: _____
Is your child currently taking any medications? ☐ Yes ☐ No
Please list all **medications**: _____
Does your child have allergies to any medications or food? ☐ Yes ☐ No
Please list all **allergies**: _____

I certify that I have read and understand the above information. The above questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payers and/or health practitioners. I also authorize the dental staff to perform the necessary dental service my child may need.

Parent/Guardian Name: _____ Signature: _____
Relationship to child: _____ Date: _____

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Financial Policies

We have several financial policy options available for your convenience in receiving the proper dental care. We have found that our patients appreciate knowing exactly what dental financial responsibilities they will incur. Therefore, we inform our patients about our financial policies before we begin treatment. Knowing this ahead of time allows us all to arrange for the completion of the necessary dental treatment.

- **Dental Insurance**
  Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed.
  Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental fees. We will be glad to process your insurance forms at no charge.
  Please be aware that we are only capable of approximating your portion due to the large number of insurance companies and to their periodic changes within their contracts without notifying each dental office of these changes.

- **Cash or Check**
  Payment in full is due when services are performed.

- **Mastercard, VISA, American Express or Discover**

- **Care Credit**
  We've made arrangements with Care Credit that will finance your dental work with approved credit. No interest payment plans are available. This will allow you to complete your dental work without delay and make relatively small monthly payments. Application forms are available at the reception desk.

- **5% Prepayment Bookkeeping Courtesy**
  On services over $100, a 5% reduction will be given when paid in full prior to that appointment date. A refund will be made if the proposed treatment is not completed.

- **Senior Citizen Courtesy**
  For our patients 65 years or older, we offer a 5% fee reduction. On services over $100, an additional 5% reduction will be given if paid prior to your appointment date.

- **Gradual Treatment Plan**
  If it will be easier financially for those patients without dental insurance, we can plan the completion of your dental work by spreading your appointments over several months or years. We will arrange to do the more urgent services at the beginning of treatment.

A specific amount of time is reserved especially for your and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice**.

Responsible Party Signature: _____

Relationship: _____ 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 Grove Street Family 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.

Grove Street Family 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 each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	☐ YES	☐ NO
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ YES	☐ NO
OTHER:	☐ YES	☐ NO

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative'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:	

STATEMENT OF PRIVACY PRACTICES OVERVIEW

Our office is dedicated to protecting 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 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.