Print Form

Stephanie Su, DDS & Purva Merchant, BDS, MSD
Redmond Kids' Dentistry

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: ◯ M ◯ F Birth Date: _____

Phone (H): _____ (Cell): _____ (Wrk): _____ Best contact number: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Best email for confirming appointments: _____

Are child's parents: ☐ Married ☐ Divorced ☐ Never been married ☐ Separated ☐ Legal Guardian

With whom does the child reside? _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend/relative ☐ Internet

☐ Dental Office ☐ Pediatrician ☐ Redmond Reporter ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Family Information

Father/Guardian Name: _____

Social Security #: _____ Birth Date: _____

Phone (H): _____ (Cell): _____ (Wrk): _____ Best time to call: _____

Address: _____
Street Apartment # City State Zip Code

Employer Name: _____ Occupation: _____

Insurance Plan Name: _____

Phone: _____ Group #: _____ ID#: _____

Mother/Guardian Name: _____

Social Security #: _____ Birth Date: _____

Phone (H): _____ (Cell): _____ (Wrk): _____ Best time to call: _____

Address: _____
Street Apartment # City State Zip Code

Employer Name: _____ Occupation: _____

Insurance Plan Name: _____

Phone: _____ Group #: _____ ID#: _____

Emergency Contact: _____ **Phone:** _____

Relation to patient: _____

Medical History

Name of medical doctor/pediatrician: _____ Phone/Address: _____

Date of last visit? _____ Reason? _____

Is your child currently under the care of a physician for anything aside from well checks? ◯ Y ◯ N Reason?

_____

Describe your child's overall physical health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any medications currently taking: _____

_____

Has your child ever been hospitalized or under a physician's care in the last two years? ◯ Y ◯ N

If so, why? _____

For Females: Taking birth control? ◯ Y ◯ N Pregnant? ◯ Y ◯ N Due Date? _____

Has your child had any of the following? Please check those that apply:

- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Asthma
- ☐ A.D.D./A.D.H.D.
- ☐ Arthritis
- ☐ Autism Spectrum
- ☐ Birth Defect
- ☐ Bladder Problems
- ☐ Blood transfusions
- ☐ Bone Disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Eating Disorders
- ☐ Epilepsy-Seizures
- ☐ Hearing Trouble
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Jaundice (☐ at birth)
- ☐ Joint Replacement
- ☐ Kawasaki Disease
- ☐ Kidney Disease
- ☐ Learning Disabilities
- ☐ Liver Disease
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Psychiatric Care
- ☐ Sensory Processing Issues
- ☐ Sinus Trouble
- ☐ Speech Delay
- ☐ Tuberculosis
- ☐ Other _____

_____

_____

Allergy/Adverse Reaction to:

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex Allergy
- ☐ Nitrous Oxide (Laughing Gas)
- ☐ Nickel Allergy
- ☐ Novocain/Xylocaine
- ☐ Antibiotic Allergy

Type: _____

- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Valium
- ☐ Food, Environmental, Other

(please list): _____

_____

Are there any other conditions we should know about?

Dental History

Is this your child's first dental visit? ◯ Yes ◯ No

If No, Former Dentist _____ Address: _____ Phone: _____

Date of Last Dental Visit: _____ Date of last x-ray: _____

Reason for this visit? _____

Does your child brush daily? ◯ Yes ◯ No Floss? ◯ Yes ◯ No

Does an adult assist with brushing/flossing? ◯ Yes ◯ No

Does you child experience pain or discomfort in the jaw joint? ◯ Yes ◯ No

Has your child experienced a mouth or jaw injury? ◯ Yes ◯ No

Was/Is your child bottle fed/breast feeding? ◯ Yes ◯ No If yes, how long? _____

Dental History (continued)

Does your child have any speech problems? ◯ Yes ◯ No If yes, are you seeing a speech therapist? ◯ Yes ◯ No

Has your child ever experienced an adverse reaction during or in conjunction with a medical/dental procedure? ◯ Yes ◯ No

Is fluoride taken in any of the following forms? ☐ Water supply ☐ Vitamins ☐ Toothpaste ☐ Tablets ☐ Rinse/Gel

Other information about your child's dental health or previous treatment

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are any changes in my child's health status, I will inform the doctor at the next appointment without fail.

Signature of parent or guardian

Date:

Office Policies

Appointment Times

The most popular times for appointments are early morning and late afternoon, due to school schedules. Also popular are no-school days. These time and days will book well in advance. In general, we suggest younger children (ages 5 and under) be scheduled in the morning. When at all possible we advise parents of very young children not to schedule appointments during their children's nap time. We will do our best to work with the needs of your child, in scheduling their appointments, but understand that quite possibly your child will need to miss school in order to arrange the optimum time for their dental care.

Confirmation and Cancellations

Our system automatically sends an email reminder 3 weeks in advance and 4 days in advance of your appointment. We have reserved specific time in our schedule just for your child and their particular needs. In addition, we have scheduled staff in accordance with the schedule. Confirmation of each child's appointment is therefore critical. **Please take a moment to confirm your child's appointment on your confirmation email or text, by clicking the provided button within the confirmation so that we receive notification that you do, indeed, intend to arrive as scheduled.** We require that you give 24 hours notice when cancelling appointments, so that we may have the opportunity to offer this time slot to another child in need of care. Please keep in mind that if you are late for an appointment we may require you to reschedule in order to avoid impacting other patients and the rest of our schedule for that day. If we do require rescheduling your appointment, due to your tardiness, it will be considered a missed or “broken” appointment. If a pattern of short cancellations, or “broken appointments” occurs (more than one in a 12 month period) we reserve the right to charge for the missed appointment time.

Insurance and Financial Responsibility

As a courtesy, we will bill your insurance after each visit. Please be aware that dental insurance is meant to assist in the cost of dental care, not eliminate it completely. This is a benefit that your employer has paid for in order to provide more ease in the financial responsibility of attaining healthcare for your family. We are a contracted provider for **Premera** and **Regence,** but can bill any insurance company your employer has chosen to provide for you. It is the responsibility of each patient to know if they have a deductible, or a different level of coverage by seeing and out-of-network, or non-contracted provider. In addition, there are annual maximums that differ from one policy to the next. Please take a few moments to familiarize yourself with your own policy to avoid un-expected cost over-runs. Redmond Kids' Dentistry will bill only one party for account balances. In the cases where a parenting plan exists, the parent that brings the child in for the

(continued)

Insurance and Financial Responsibility (continued)

appointment is considered the guarantor and is responsible for payment. They may seek reimbursement from the other parent. **All unpaid balances are the responsibility of the patient/parent within 90 days, *regardless of insurance coverage.*** Failure to pay will result in a delay of treatment, and additional fees for collection of the account. **Non-Insured patients are required to pay for services the day of treatment.** To assist in payment, we accept Cash, Checks, VISA and MasterCard.

Consent for Dental Treatment

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. I understand that whoever accompanies my child to their dental appointment has authorization to consent to dental care as needed.

I hereby authorize the doctors at Redmond Kids Dentistry, assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following treatment, if needed or recommended:

- Preventive services as deemed necessary such as:
- Examination of the teeth, mouth and neck including radiographs (x-rays)
- Cleaning of the teeth and application of fluoride and of sealants
- Treatment of injured or diseased teeth as the doctor deems necessary and in the manner that the doctor recommends

I further authorize the doctors to perform other dental services that in their judgment are advisable for my child or legal ward, with the exception of:

_____

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 and injuring their tongue or lip following the administration of local anesthesia. For children with heart disease, the risk of sub acute 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 that, though rare, complications may require additional medical, dental or surgical treatment and may require hospitalization.

I also authorize the professional use of photographs, radiographs, other diagnostic materials and treatment records for the purpose of collaborating with other dental and medical specialists in the care of my child. I further authorize the use of such materials for the purposes of teaching, research, or scientific publications.

Photo/Model Release

I give Redmond Kids' Dentistry permission to use my or my child's name, image, likeness, or voice, for the purposes of advertising, publicity, fundraising, and promotion of Redmond Kids' Dentistry, including in its internal publications; for Redmond Kids' Dentistry publicity in external publications such as local, regional and national newspapers and magazines, or Facebook; and for retail items. There is no expiration date on this release and I will not seek compensation for usage.

Please Initial YES _____ or **NO** _____

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 Redmond Kids' 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 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.

Redmond Kids' Dentistry 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 information to the persons indicated below.

ANY MEMBER OF MY FAMILY (parents, grandparents, other relatives, etc…) ◯ Yes ◯ No

SPOUSE ONLY ◯ Yes ◯ No

OTHER (please specify, i.e.: nanny, friend, step-parent, babysitter…) ◯ Yes ◯ No

_____

Stephanie Su, DDS @ Purva Merchant, BDS, MSD
Redmond Kids' Dentistry

I hereby state that I have read and understand this form, and that I have the 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 anytime, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

I state that I have read and agree to all of the terms as stated above. I understand and agree that signing this form holds me ultimately financially responsible for any account balance.

_____
(Name of Patient)

_____ _____
(Name of Parent/Guardian) (Relationship to Patient)

_____ _____
(Signature) (Date)