Welcome to The Kids' Dentist
NEW PATIENT FORMS

TODAY'S DATE _____

CHILD'S FIRST NAME _____ **MI** _____ **LAST NAME** _____

PREFERRED NAME: _____

MALE ☐ **FEMALE** ☐ **DATE OF BIRTH** _____-_____-_____ **AGE** _____

ADDRESS_____

CITY_____ **STATE** _____ **ZIP** _____

PLEASE LIST IN ORDER THE BEST NUMBERS TO REACH YOU REGARDING YOUR CHILD'S DENTAL APPOINTMENTS:

PHONE #1 _____-_____-_____ ☐ **CELL** ☐ **HOME** ☐ **WORK**

PHONE #2 _____-_____-_____ ☐ **CELL** ☐ **HOME** ☐ **WORK**

PHONE #3 _____-_____-_____ ☐ **CELL** ☐ **HOME** ☐ **WORK**

CAN YOU RECEIVE TEXT MESSAGES ON YOUR CELL PHONE? ☐ **YES** ☐ **NO**

EMAIL _____

HOW DID YOU HEAR ABOUT US? _____

FATHER'S/GUARDIAN'S FULL NAME _____ **DOB** _____

MOTHER'S/GUARDIAN'S FULL NAME _____ **DOB** _____

PERSON RESPONSIBLE FOR MAKING DENTAL APPOINTMENTS AND FINANCIAL ARRANGEMENTS _____

OTHER CHILDREN IN FAMILY (NAMES AND AGES) _____

AUTHORIZATION

I authorize The Kids' Dentist to release any and all medical or dental information for evaluation, treatment, and any anticipated care. I understand that I am responsible for any and all charges (including collection fees). I understand that the estimated patient portion is due at the time that services are rendered, unless other arrangements have been made for payment. I also understand that any treatment estimate that is given to me is done in good faith and I understand that my insurance may not pay the amounts estimated by The Kids' Dentist. I understand that I am responsible for knowledge of my insurance program and the limitations of it. I have read this authorization and understand its contents.

SIGNATURE _____ **DATE** _____

RELATIONSHIP TO PATIENT _____

The Kids Dentist

364 Renton Center Way SW, Suite 62
Renton, WA 98057
P: 425-255-5532
F: 425-255-1658

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 The Kids' Dentist. 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.

The Kids' Dentist 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 state 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 child's Protected Healthcare Information to the person(s) identified below (other than me). (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual questions, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

My Spouse	☐ **YES**	☐ **NO**
Any member of my immediate family (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any member of my extended family (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:		
Name of Patient:		
Patient Signature (If 18 years or older)		
Parent/ Guardian:		
Parent/ Guardian Signature: **Date:**		
Representative's Telephone Number:		

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 of Privacy Practices**
		☐	**Wanted to consult another person before signing**
		☐	**Physically unable to sign**
		☐	**No reason offered**
		☐	**Other:**

REVISED 10/01/2014

Health History Form

GENERAL INFORMATION

Patient Name _____ DOB _____ Weight _____

Parent/ Guardian filling out form _____ Describe child's temperament_____

Is your child adopted? No Do they know? No Is this a foster child? No

DENTAL INFORMATION

NEW PATIENTS ONLY: Name of previous dentist _____ Phone # _____

Date of last dental exam_____ Cleaning _____ Xrays_____

Is there a particular concern you would like examined today? _____

Hass your child had any negative dental or medical experiences? _____

Is your child currently taking fluoride drops/tablets? Select If yes, how much/when_____

Does your child drink water from the tap? Select Bottled Water? Select

ALL PATIENTS: Does your child <u>have</u>, or have they <u>had</u> any of the following? Please check all that apply

- ☐ TMJ, painful or locking jaw
- ☐ Nursing or bottle feeding at night
- ☐ Thumb sucking/ pacifier
- ☐ Grinding or clenching of teeth
- ☐ Tongue thrust
- ☐ Mouth breather, nail biting

MEDICAL INFORMATION

Child's Physician _____ Phone # _____

Date of last exam _____ Are your child's immunizations up to date? _____

FEMALE PATIENTS: Is there any chance you might be pregnant? Select Are you taking birth control pills? Select

Has your child ever been hospitalized? Select Injuries/ surgeries_____ Date_____

Does your child have any allergies or reactions (aspirin/pain medications, food, antibiotics, latex, preservatives/flavorings, etc)? Select

_____

Any medication taken on a regular basis (prescription, over the counter, vitamins, etc.)? _____

Has your child ever <u>had</u> or does he/she <u>now have</u> any of the following diseases/conditions? Please check all that apply.

- ☐ Heart disease, murmurs, or rheumatic fever
- ☐ Low or high blood pressure
- ☐ Kidneys, Endocrine, Liver (hepatitis), GI, Thyroid
- ☐ Cancer, tumors, other growths
  If yes, radiation or chemotherapy Date _____
- ☐ Epilepsy, seizures, or fainting
- ☐ Congenital birth defects _____
- ☐ Diabetes, arthritis
- ☐ Asthma If yes, treatment _____
- ☐ Other breathing problems/ diseases of lung (TB)
- ☐ Bleeding problems or diseases of the blood
- ☐ Blood transfusions? Date _____
- ☐ Sinusitis, seasonal allergies
- ☐ Cold sore, canker sores
- ☐ Venereal or other serious infections
- ☐ Problems with vision or hearing
- ☐ Fever, sore throat/tonsils, ear aches/infections
- ☐ Frequent/recurrent headaches or migraines
- ☐ Dietary restrictions_____
- ☐ Childhood diseases_____
- ☐ Immunological problems or diseases (Leukemia, AIDS/HIV)
- ☐ Tobacco use (any form)
- ☐ Chemical dependencies
- ☐ Emotional problems
- ☐ Learning or behavioral problems *
- ☐ Developmental delay/ mental challenges *
- ☐ Autism spectrum or sensory issues *

* **If you answered yes to the last 3 questions, please fill out the Supplemental Health History form**

Are there any other conditions or anything else we should know about your child? _____

_____ _____

Parent Signature Date Provider Signature Date

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? ☐ **YES** ☐ **NO** **If yes, please fill out the section below**

PRIMARY SUBSCRIBER'S NAME _____

DATE OF BIRTH _____ **SS#** _____

ID NUMBER (IF YOUR INSURANCE DOES NOT USE SS#) _____

EMPLOYER _____ **WORK NUMBER** _____

DENTAL INSURANCE NAME AND CLAIMS ADDRESS _____

_____

_____

GROUP NUMBER _____ **INSURANCE PHONE NUMBER** _____

EFFECTIVE DATE _____

DO YOU HAVE SECONDARY DENTAL INSURANCE? ☐ **YES** ☐ **NO** **If yes, please fill out the section below**

SECONDARY SUBSCRIBER'S NAME _____

DATE OF BIRTH _____ **SS#** _____

ID NUMBER (IF YOUR INSURANCE DOES NOT USE SS#) _____

EMPLOYER _____ **WORK NUMBER** _____

DENTAL INSURANCE NAME AND CLAIMS ADDRESS _____

_____

_____

GROUP NUMBER _____ **INSURANCE PHONE NUMBER** _____

EFFECTIVE DATE _____

***** PLEASE KEEP IN MIND THAT TO BILL YOUR INSURANCE CORRECTLY WE NEED ACCURATE, UP TO DATE INFORMATION. PLEASE HAVE YOUR CARD AVAILABLE SO WE CAN MAKE A COPY FOR YOUR CHILD'S FILE. *****

AUTHORIZATION

I UNDERSTAND THAT I AM RESPONSIBLE FOR KNOWING MY INSURANCE PLAN PROVISIONS AND LIMITATIONS AND THAT ANY INFORMATION I GIVE WILL BE USED TO BILL MY INSURANCE FOR TREATMENT RENDERED IN THE OFFICE. I UNDERSTAND THAT THE KIDS' DENTIST MAY NOT BE A PREFERRED PROVIDER WITH MY INSURANCE. I ALSO UNDERSTAND THAT EVEN IF I HAVE INSURANCE, THE KIDS' DENTIST MAY ASK FOR THE PORTION THAT MY INSURANCE DOES NOT COVER AT THE TIME SERVICES ARE RENDERED, AND THAT I AM ULTIMATELY RESPONSIBLE FOR MY ACCOUNT.

SIGNATURE _____ **DATE** _____

JARED LOTHYAN, DDS BRYAN WILLIAMS, DDS BRIAN DANSIE, DDS

The Kids Dentist
CONSENT FOR DENTAL TREATMENT

1. 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.

2. I hereby authorize Dr. Lothyan, Dr. Dansie, and/ or Dr. Williams, assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following dental treatment or oral surgery procedures:

Exam, Prophy Cleaning, Fluoride, X-Rays, Extractions, Composite (tooth-colored) Fillings, Stainless Steel Crowns, Pulp (nerve) Therapy, Space Maintainer Placement & Sealants.

Dr. Lothyan, Dr. Dansie, and/or Dr. Williams, have explained the nature and purpose of the treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, risks, consequences and probable effectiveness of each, as well as prognosis if no treatment is provided.

I am advised that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as the cure. I further authorize Dr. Lothyan, Dr. Dansie, or Dr. Williams, to perform other dental service(s) that in their judgment are advisable for my child or legal ward, with the exception of (if none, so state):

None

3. 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 or injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting,

allergic reactions, swallowing or aspiration of a crown form, extracted tooth or gauze packing; injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings). Injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. 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 the complications may require additional medical, dental or surgical treatment and may require hospitalization.

Additional risks include:

4. I also authorize Dr. Lothyan, Dr. Dansie, and/or Dr. Williams to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, or scientific purposes.

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner; and I understand further that I have a 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 any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

Patients' Name(s):	
Parent/Guardian's Name:	
Signature of Parent/Guardian:	
Date:	Time:
Relationship to Patient:	
Witness Signature:	

Email Forms