moses lake
pediatric dentistry

800 N. Stratford Rd • Moses Lake • WA • 98837 • (509) 765-2255

CHILD'S FULL NAME _____ Preferred Name _____

❑ Male ❑ Female Birthdate _____ Age _____

School _____

❑ **Stepfather** ❑ **Guardian**

FATHER'S NAME _____ Birthdate _____ Social Security No. _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Employer _____ Work Phone _____

Cell Phone _____ Best Contact# _____ Email _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ **Stepmother** ❑ **Guardian**

MOTHER'S NAME _____ Birthdate _____ Social Security No. _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Employer _____ Work Phone _____

Cell Phone _____ Best Contact# _____ Email _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

With whom does this child reside? _____

Email Address _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insured _____	Insured _____
Insurance Co. _____ Group # _____	Insurance Co. _____ Group # _____
Insured Birthdate _____	Insured Birthdate _____
Insured ID/SS No. _____	Insured ID/SS No. _____

❑ No dental insurance

Person financially responsible for child's account: _____

* * * * * *

IN CASE OF EMERGENCY, *OTHER THAN THOSE LISTED ABOVE* WHOM MAY WE CONTACT?

Name _____ Home Phone _____ Work Phone _____

Relationship to Patient _____

How did you hear about our office? ❑ ❑ Word of mouth ❑ Drive by ❑ Dr. _____ reffered ❑

CHILD'S FULL NAME _____ Preferred Name _____

❑ Male ❑ Female Birthdate _____ Age _____

Please answer all questions, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. *Thank You*.

MEDICAL HISTORY

Is your child presently under the care of a physician? ..... ❑ Yes ❑ No
If so, for what condition? _____

Child's Physician _____ Office Name _____ Phone _____

Date of last physical exam _____ Findings _____

Former Dentist _____ Office Name _____ Phone _____

Is your child:

In good health? ..... ❑ Yes ❑ No

Sensitive or allergic to any medications or latex? ..... ❑ Yes ❑ No
If yes, please list: _____

Taking any medications? ..... ❑ Yes ❑ No
If yes, please list: _____

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

Does your child have any history of the following conditions (please choose):

❑ Yes ❑ No Asthma	❑ Yes ❑ No Diabetes	❑ Yes ❑ No Liver Disease	❑ Yes ❑ No Hearing Difficulty
❑ Yes ❑ No Bleeding Problem	❑ Yes ❑ No Thyroid Problem	❑ Yes ❑ No Kidney Disease	❑ Yes ❑ No Speech Delay
❑ Yes ❑ No Blood Transfusion	❑ Yes ❑ No Seizure or Epilepsy	❑ Yes ❑ No Tuberculosis (TB)	❑ Yes ❑ No Development Delay
❑ Yes ❑ No Heart Problem	❑ Yes ❑ No Motor or Muscle Disorder	❑ Yes ❑ No HIV/AIDS	❑ Yes ❑ No Psychiatric Problem
❑ Yes ❑ No Heart Murmur	❑ Yes ❑ No Fainting or Dizziness	❑ Yes ❑ No Autistic	❑ Yes ❑ No ADD / ADHD

Does your child have any other Problems, Conditions or Special Needs?
_____

Has your child had any history of binky, thumb or finger sucking, pacifier use, lip biting? (If yes, circle condition) ❑ Yes ❑ No
Is your child taking fluoride pills or drops? ..... ❑ Yes ❑ No
Is your child in any contact sports? ..... ❑ Yes ❑ No
Has your child ever had an orthodontic evaluation or treatment (braces)? ..... ❑ Yes ❑ No
Name of Orthodontist _____
Is there any other information which will assist us in providing the best possible care for your child?
Please state here _____
Were you referred to our office? ..... ❑ Yes ❑ No
If so, whom may we thank _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Cox and/or dental staff to perform the necessary dental services my child may need. This may include exams, radiographs, cleanings, topical fluoride treatment, restorative dentistry, oral surgery or limited orthodontics. In order to perform such treatment, our team may recommend the use of local anesthesia (numbing) and/or nitrous oxide (laughing gas).

Parent/Guardian Signature _____ Date _____
Dentist Signature _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided at the beginning of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices

* You may Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date_____

- Patient Financial Policy -

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In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your child's care.

We are committed to support you in understanding your child's dental health, and will always present you with the best dental solution possible to treat your child's personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options. Please select one.

- ☐ Cash, Check or Debit
- ☐ Visa, MasterCard, Discover, American Express
- ☐ Care Credit

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party) Date

- Consent for Use of Photograph -

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Parent/Guardian:

As you are aware, there are potential dangers associated with the posting of personally identifiable information. The law requires that we ask for your permission to use information about your child.

I , _____, authorize Moses Lake Pediatric Dentistry to use my child's photograph and personally identifiable information to be published online (Facebook, etc).

Child's Name: (please print)_____

Parent/Guardian:

(please print)_____

Signature of Parent/Guardian:_____

Date: _____

