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www.cwpediatricdentistry.com

ABOUT YOUR CHILD

Child's Name_____Nickname_____ Male/ Female

Birthdate____/____/_____ Special interest, sports and/or hobbies _____

Mailing Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone _____ Work Phone_____

Email Address _____ Guarantor of child's account_____

Preferred Contact Method for Billing: Phone / Email / Text (please circle one)

Father/Guardian's Name _____ Mother/ Guardian's Name _____

Are you the foster parent: Yes/No If so, who makes health care decisions for the child? _____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT?

Name_____ Phone Number_____ Relationship to child_____

PRIMARY DENTAL INSURANCE

Subscriber _____Birthdate _____/_____/_____Employer _____

Insurance Co. _____Subscriber ID or Social Security Number_____

SECONDARY DENTAL INSURANCE

Subscriber _____Birthday _____/_____/_____Employer _____

Insurance Co. _____Subscriber ID or Social Security Number_____

HOW DID YOU HEAR ABOUT US? _____

Was your child referred to our office? **Yes/No** If so, who may we thank? _____

PHYSICIAN INFORMATION

Is your child under the care of a physician? **Yes/No** If so, for what condition? _____

Child's Physician Office_____ Phone Number _____

Date of last physical exam _____ Findings? _____

MEDICAL HISTORY

Does your child have any allergies? **YES/ NO** If yes, please list: _____

Is your child taking any medication? **YES/NO** If yes, please list: _____

Has your child had any previous surgeries and/or been hospitalized? **YES/NO** If yes, please describe and provide dates:

_____

Was your child "Full Term" (37+ weeks)? **YES/NO** Are their shots up to date? **YES/ NO**

Does your child have any of the following conditions (please circle all that apply)?

Anemia	Asthma	Seizure/Epilepsy	Developmental Delay
Bleeding Disorder	Lung Disease	Cerebral Palsy	Psychiatric Problems
Blood Transfusion	Tuberculosis (TB)	Motor/Muscle Disorder	ADD/ADHD
HIV/AIDS	Kidney Disease	Headaches	Learning Disability
Heart Murmur	Hepatitis	Fainting/Dizziness	Autism
Heart Defect/Problem	Tumor	Hydrocephalus	Hearing Impairment
Diabetes	Cancer	Congenital Birth Defect(s)	Speech Delay/Disorder
Endocrine Problem	Drug Reaction	Frequent Infections	Vision Impairment
Thyroid Problem	High Blood Pressure	Sinus Problems	Skin Problems/Rash

Does your child have any other conditions? _____

Does your child need to be pre-medicated for dental treatment? **YES/NO**

DENTAL HISTORY

Previous dental home? _____ When was their last dental visit? _____

Has your child complained about dental issues? **YES/NO**

Has your child had any injuries to their mouth, teeth or head? **YES/NO** If yes, please describe_____

Does your child have any of the following habits?

Thumb Sucking	Bottle use at Bedtime
Nail Biting	Snoring/Mouth Breathing
Pacifier	Grinding

How often do they brush their teeth? _____

How often do they floss their teeth? _____

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

Parent/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____

FINANCIAL POLICY

Thank you for choosing Central Washington Pediatric Dentistry as your child's dental home. In an interest of good communication and our continued commitment to provide the highest quality of dental care available, 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 choice(s) related to your child's dental care.

We are committed to supporting you in understanding your child's oral health and will always present you with the best solution possible to treat their personal dental need. To make these services comfortably affordable, we are pleased to offer you the following payment options:

1. Cash or Personal Check
2. Debit Card and/or Credit Card
3. Care Credit
4. Layaway/Pre-payment plans

Payment for services is due at the time the service is provided. We will, as courtesy, process your insurance claim in our office. All questions regarding your insurance benefits must be addressed with your insurance carrier(s). **We do not determine benefits**. We do our best to assist you in estimating your portion of the cost for the treatment recommended by the Doctors. We are not responsible for any errors when filing your insurance as this is a courtesy we offer.

I agree that I am fully responsible for all fees charged by Central Washington Pediatric Dentistry regardless of my insurance coverage. I understand that an estimated portion, not covered by insurance, is due at the time of service for all services rendered. I understand that all services are due and to be paid within sixty (60) days of the date of service, regardless of whether or not my insurance benefits have been received. Most insurance companies will make payment with 30 days of receiving the claim. We will send you a monthly statement. Please call if your statement does not reflect your insurance payment. Any remaining balance after your insurance has paid is your responsibility. If your account balance has not been paid within 60 days from the date of service, a 1.5% fee will be added to your account each month until paid. We will gladly refund this fee if your insurance pays us.

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PARCTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for Central Washington Pediatric Dentistry. The Notice describes the types of uses and disclosures of my child's protected health care information that might occur in their treatment, payment of services, or in the performance of the office's health care operations. The Notice also describes your rights, responsibilities and duties of this practice with respect to your child's protected health information. The Notice is also posted in the facility.

Central Washington Pediatric Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITONAL DISCLOSURE AUTHORTIY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my child's protected health care information to the persons indicated below. If, any please list below:

_____

Name_____ Relationship to Child_____

Parent/Guardian Signature_____ Date_____