SMALL TO TALL PEDIATRIC DENTISTRY

Olympia WA 98506
Phone: 360.459.5885 • Fax: 360.459.7115 • www.smalltotall.info

CHILD'S HISTORY

(These questions are of great value in aiding us in the treatment and better understanding of your child.)

Child's Name _____ Nickname _____

Birthdate _____ Male/Female Birthplace _____
Month - Day - Year

Parent(s)/Guardian(s) Name _____

Who is the custodial parent(s) _____

DENTAL INFORMATION:

Family dentist _____ Phone No. _____

1. Is there a particular situation you would like examined today? ☐ Yes ☐ No If "yes", explain: _____

2. When was your child's last dental checkup and cleaning? _____

3. Has your child been seeing a dentist for regular checkups and care? ☐ Yes ☐ No

4. Has your child had any negative experiences with dentists or doctors? ☐ Yes ☐ No What, if any: _____

5. Taking Fluoride? ☐ Yes ☐ No

MEDICAL INFORMATION:

Child's physician _____ Phone No. _____

Address _____

1. Does your child have or has your child ever had any of the following:

	YES	NO
A) Heart disease, murmur or rheumatic fever? **If yes**, antibiotic documentation will be required from patient's physician.	☐	☐
B) High or low blood pressure	☐	☐
C) Hay fever, sinus problems, or allergies	☐	☐
D) Herpes or cold sores	☐	☐
E) Diabetes	☐	☐
F) Low birth weight / premature	☐	☐
G) Autism / Autism Spectrum Disorder	☐	☐
H) Cerebral Palsy	☐	☐
I) Kidney disease	☐	☐
J) Cancer, tumors, other growths	☐	☐
K) Radiation or chemotherapy	☐	☐
L) Reactions or allergies to any of the following: ☐ Aspirin or other pain medication ☐ Foods ☐ Latex ☐ Antibiotics ☐ Dental anesthetics ☐ Other (food dye, etc.) If yes to any of above, specify	☐	☐
M) Immunologic deficiency disease (Leukemia, AIDS/HIV positive, other)	☐	☐
N) Liver disease (Hepatitis, jaundice)	☐	☐
O) Thyroid problems	☐	☐
P) Lung disease (TB, asthma, persistent cough, other)	☐	☐
Q) Epilepsy, seizures, fainting spells	☐	☐
R) Arthritis	☐	☐
S) Sore throats, tonsillitis, earaches	☐	☐
T) Venereal disease	☐	☐
U) Abnormal bleeding or blood disorders If yes, what _____	☐	☐
V) Smoke or use other forms of tobacco	☐	☐
W) Does your child receive regular vaccinations / immunizations	☐	☐
X) ADD or ADHD	☐	☐
Y) Behaviour and/or emotional problems	☐	☐
Z) Take any drugs or medications, prescription or non-prescription If yes, what _____	☐	☐
AA) Is your child adopted?	☐	☐
Does he/she know?	☐	☐
BB) Has your child been treated or currently being treated for any chemical dependency?	☐	☐

Any other conditions/syndromes (Example: Down syndrome, cleft lip/palate) we should be aware of? _____

FEMALES

Is there any possibility your child could be pregnant? ☐ ☐ Does she take birth control medication? ☐ ☐

_____ Date _____
Parent/Guardian

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CHILD'S NAME _____ (Last) _____ (First) _____ (Initial)

☐ MALE ☐ FEMALE BIRTHDATE _____ AGE _____

HAS ANY OTHER IMMEDIATE FAMILY MEMBER BEEN TREATED AT THIS OFFICE? ☐ YES ☐ NO _____ (Name)

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FATHER ☐ STEPFATHER ☐ GRANDFATHER ☐ LEGAL GUARDIAN ☐

_____ (Last) _____ (First) _____ (Initial)

SOCIAL SECURITY NO. _____ BIRTHDATE _____ ☐ Married ☐ Separated ☐ Divorced ☐ Single

ADDRESS _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ (Street or P.O. Box) _____ (Apt) _____ (City) _____ (State) _____ (Zip)

DENTAL INSURANCE CO. _____ GROUP #/ID _____
(Info. Needed Only if Patient is Covered on This Policy)

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

Email Address: _____ Dad, Mom or Family? Home or Work?

MOTHER ☐ STEPMOTHER ☐ GRANDMOTHER ☐ LEGAL GUARDIAN ☐

_____ (Last) _____ (First) _____ (Initial)

SOCIAL SECURITY NO. _____ BIRTHDATE _____ ☐ Married ☐ Separated ☐ Divorced ☐ Single

ADDRESS _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

DENTAL INSURANCE CO. _____ GROUP #/ID _____
(Info. Needed Only if Patient is Covered on This Policy)

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

IS THE PATIENT LISTED ABOVE COVERED UNDER THEIR OWN, SEPARATE INSURANCE POLICY? YES ☐ NO ☐

IF YES: NAME OF POLICY _____ ID# _____

POLICY BILLING ADDRESS _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

Assignment and Release: I hereby authorize the insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for all claims. I acknowledge that I am financially responsible for all charges whether or not they are paid by insurance. A minimum service charge of $1.00 (not to exceed 1%) on all charges over 90 days old will be accessed.

If I desire credit to be extended to me and/or my family for services rendered, I am aware that a credit report may be obtained before credit is extended.

In the event of default of payment and or/failure to pay, I agree to pay the costs of collection including court costs and reasonable attorney fees to be determined by a court of law. (I understand and agree that)...Any legal action, arising under or related to this agreement, shall be brought and maintained exclusively in a state court of Thurston County, State of Washington, and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of any such action and hereby waive any defense related to personal jurisdiction, process or venue brought in those courts.

SIGNED _____ **DATE** _____

Small To Tall Pediatric Dentistry
3422 12th Ave NE
Olympia, WA 98506

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Rowley and Ruder, PLLC's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my child(ren)'s protected health information that might occur in his/her treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and Rowley and Ruder, PLLC 's duties with respect to my child(ren)'s protected health information. The Notice of Privacy Practices is posted in the facility.

Rowley and Ruder, PLLC 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 child(ren)'s 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.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my child(ren)'s protected health care information to the persons indicated below.				
My child(ren)'s other parent / step-parent / sibling	☐	YES	☐	NO
Grandparent or other child care provider	☐	YES	☐	NO
Other (please specify)	☐	YES	☐	NO

Name of Patient _____ **Signature of patient or personal representative** _____

Date _____ **Relationship of Personal representative** _____

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED		
PROVIDED PRIOR TO TREATENT?	☐ YES ☐ NO	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):

EMERGENCY CARE INFORMATION

Patient Name _____ Birthdate _____

Mailing Address _____ City _____

Street Address _____ City _____

Home Phone ( ) _____ Mom's work ( ) _____ Cell ( ) _____

Dad's work ( ) _____ Cell ( ) _____

Parent / Guardian Name(s) _____

Emergency Contact _____ Phone ( ) _____

Emergency Contact _____ Phone ( ) _____

Patient's Medical Doctor _____ Phone ( ) _____

Preferred Hospital _____ City _____

Medical Insurance Name: _____ Subscriber: _____

Employer _____

Group # _____ ID# _____

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

_____

Is your child allergic to any medications or products? YES NO If yes, please list:

_____

Does your child have any special medical problems or concerns? _____

_____

If I can not be reached in case of serious illness or injury to my child, I hereby delegate my authority to Drs. Psaltis, Rowley & Ruder, or their designee to seek medical attention for mychild.

Signature of Father or Guardian _____ Date _____

Signature of Mother or Guardian _____ Date _____

Print Name: _____

CONTACT INFORMATION

Parent Name: _____

Child(ren)'s name(s): _____

- E-mail Address: _____
- Cell Phone: _____
- Home Phone: _____
- Work Phone: _____

Which is your preferred number?
Please check only one.

☐ Cell
☐ Home
☐ Work

Would you like to receive a text message appointment reminder on your cell phone?

☐ Yes
☐ No

We send appointment reminders by email 2 business days prior to your appointment. Text messages are sent 48 hours and also 1 hour beforehand. Depending on your wireless service plan, your wireless provider may charge you for text messages that you receive. You will be responsible for those charges, if any.

YOU ARE RESPONSIBLE FOR KEEPING YOUR CHILD(REN)'S APPOINTMENTS.

All confirmations are a courtesy we provide our patients. Please be aware of our cancellation policy:

Office Cancellation Policy requires that you give us a minimum of 24 hours notice for all appointments as your appointment time has been specifically reserved for you. By giving us this notice you will avoid being charged a missed appointment fee.

Signature: _____ Date: _____

PLEASE NOTE: The personal information you provide is strictly confidential and for in-office use only. All privacy rules are strictly maintained.