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)	☐	☐

	YES	NO
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):

Statement of Privacy Practices

Small to Tall Pediatric Dentistry

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your our obligations and your rights.

Protecting your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

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. Rowley & Ruder, or their designee to seek medical attention for my child.

Signature of Father or Guardian_____Date_____

Signature of Mother or Guardian_____ Date_____

SCOTT T. ROWLEY, D.M.D., M.S.D.
BENJAMIN D. RUDER, D.D.S.
ROSALEEN J. SHAVRON, D.M.D.
MAUREEN H. CRAIG, D.D.S., M.S.D.
BOARD CERTIFIED PEDIATRIC DENTISTS

Parent Guidelines and Terminology

Dear Parents,

In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

DO NOT USE	OUR EQUIVALENT
needle or shot	sleepy Juice
drill	whistle
drill on tooth	clean a tooth
pull or yank tooth	wiggle a tooth out
decay, cavity	sugar bug
examination	count teeth
tooth cleaning	tickle teeth
explorer	toothpick
rubber dam	raincoat
gas	magic air

This will help you understand your child's description of the dental experience. Our intention is to not "FOOL" the child- it is to create an experience that is positive. We appreciate your cooperation in helping us build a good attitude for your child!

You may choose whether or not to remain in the waiting room during your child's filling appointment. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome.

1) Allow us to prepare your child
2) Be supportive of the practice's terminology
3) Please be a silent observer- support you child with touches
    A) This allows us to maintain communication with your child
    B) Children will normally listen to their parents instead of us and may not hear our guidance
    C) You might give incorrect or misleading information
4) If asked to leave, be ready to immediately walk away
    A) Many children try to control the situation
    B) "Acting Out" is normal, but not acceptable during fillings
    C) This is intended to "short circuit" the control attempts
    D) We will continue to support your child at all times

These are very important ways that can actively help in the success of your child's visit. We are confident that all will go well and hope the guidelines will help prepare you with confidence for the upcoming appointment

Date_____Signature:_____

Print Name_____