# SMALL TO TALL PEDIATRIC DENTISTRY

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

## CHILD'S HISTORY

Child's Name _____ Preferred Name _____
Birthdate _____ Male/Female/Other Birthplace _____
Parent(s)/Guardian(s) Name(s) _____
Legal Custodian Name(s) _____
Address _____ Employer _____

**DENTAL INFORMATION:**

Family Dentist _____ Phone Number _____
1. What is your main concern today? _____
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. Please describe any negative experiences with dentist or doctors: _____
5. Is your child taking fluoride supplements? ☐ Yes ☐ No

**MEDICAL INFORMATION:**

Child's Physician _____ Phone Number _____
Address _____
Mark if your child has or ever had any of the following:

- ☐ Heart disease, murmur or rheumatic fever?
- ☐ High or low blood pressure
- ☐ Lung disease (TB, asthma, reactive airway disease, other). If so, what are the triggers, any visits to ER? _____
- ☐ Sore throats, tonsillitis, earaches
- ☐ Diabetes (Type _____)
- ☐ Low birth weight/premature
- ☐ Autism or Autism Spectrum Disorder
- ☐ Cerebral Palsy
- ☐ Kidney disease
- ☐ Liver disease (Hepatitis, jaundice)
- ☐ Thyroid conditions
- ☐ Cancer, tumors, other growths
- ☐ Radiation or chemotherapy
- ☐ Immunodeficiency (AIDS/HIV, other)
- ☐ Hay fever, sinus problems, or allergies
- ☐ Reactions or allergies:
  - ○ Medications _____
  - ○ Foods _____
  - ○ Latex
  - ○ Other (food dye, etc)_____
- ☐ Special dietary considerations _____
- ☐ Epilepsy, seizures, fainting spells
  Date of last seizure _____
- ☐ Arthritis
- ☐ MTHFR Deficiency
- ☐ Syndromes (Trisomy 21, etc) _____
- ☐ Abnormal bleeding or blood disorders.
  Type _____
- ☐ Tobacco use
- ☐ Regular vaccinations/immunizations
  HPV Vaccine ☐ Yes ☐ No
- ☐ ADD or ADHD
- ☐ Behavior and/or emotional difficulties
- ☐ Chemical dependency
- ☐ Pregnancy
- ☐ Is your child adopted?
  If so, does he/she know? ☐ Yes ☐ No
- ☐ List any surgeries or hospitalizations: _____
- ☐ Is your child being treated by a doctor for any other reason not listed above? _____
- ☐ List any current drugs or medications, prescription or non-prescription: _____

Additional Notes:
_____
_____

_____ Date _____
*(Parent/Guardian or Patient Signature (18+))*

_____ Date _____
*(Provider Signature)*

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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<br>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. Psaltis, Rowley & Ruder, or their designee to seek medical attention for mychild.

Signature of Father or Guardian _____ Date _____

Signature of Mother or Guardian _____ Date _____

## 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.*