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? ______________________
- □ Regular vaccinations/immunizations
  HPV Vaccine □ Yes □ No
- □ Tonsillitis
- □ Diabetes (Type ______________)
- □ Low birth weight/premature; gestational age _____
- □ 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 seasonal allergies
- □ Reactions or allergies:
  - ○ Medications ______________________
  - ○ Foods ______________________
  - ○ Latex
  - ○ Other (food dye, etc)______________________
- □ Epilepsy, seizures, fainting spells
  Date of last seizure ______________________
- □ Special dietary considerations ______________________
- □ Arthritis
- □ MTHFR Deficiency
- □ Syndromes (Trisomy 21, etc) ______________________
- □ Abnormal bleeding or blood disorders.
  Type ______________________
- □ Tobacco use
- □ 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 ______________________________

☐ MALE ☐ FEMALE BIRTHDATE ______________ AGE ______________

HAS ANY OTHER IMMEDIATE FAMILY MEMBER BEEN TREATED AT THIS OFFICE? ☐ YES ☐ NO ______________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

Please circle one: Mother/Father Stepmother/Stepfather Grandmother/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 ______________

EMAIL ______________________________

EMPLOYER ______________________________ OCCUPATION ______________

ADDRESS ______________________________
Street or P.O. Box City State Zip

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

Please circle one: Mother/Father Stepmother/Stepfather Grandmother/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 ______________

EMAIL ______________________________

EMPLOYER ______________________________ OCCUPATION ______________

ADDRESS ______________________________
Street or P.O. Box City State Zip

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

EMERGENCY CONTACT:

NAME(S) ______________________________ RELATIONSHIP ______________

CELL PHONE # ______________________________ HOME PHONE # ______________

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 ______________

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.

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):

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Olympia, WA 98503

Practice Terminology and Parent Guidelines

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:

DON'T 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 not to "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 positive outcome.

1) Allow us to prepare your child
2) Be supportive of the practice's terminology
3) Please be a silent observer – support your 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 unacceptable during fillings
   C) This is intended to "short circuit" the control attempt
   D) We will continue to support your child at all times

These are very important ways that you 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:____