Chart Number _____
(for internal use only)

Lindquist Dental Clinic for Children

Parkland * South Tacoma * Gig Harbor * Bremerton

Health History

Child's Name:

_____ _____ _____
Last Name First Name Date of Birth

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combination Ionimin, Adipex, Fastin (brandnames of phetermine), Pandimin (fenfluramine)

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Drug/Alcohol Addiction	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Allergies/Hives	☐Yes ☐No	Emotional or depression	☐Yes ☐No	Mumps	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy/Seizure	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Fainting or Dizziness	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Glaucoma	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Hay Fever	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Asthma	☐Yes ☐No	Headaches	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Autism	☐Yes ☐No	Hearing/Vision Impaired	☐Yes ☐No	Sickle Cell Disorder	☐Yes ☐No
Back Problems	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Bleeding abnormally, with extractions or surgery	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No	Skin Rash	☐Yes ☐No
Blood Disease	☐Yes ☐No	Heart Problems	☐Yes ☐No	Special Diet	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Heart Surgery	☐Yes ☐No	Speech Disorder	☐Yes ☐No
Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No	Stroke	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	Hepatitis Type ___	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Thyroid Problem	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hyperactive (ADHD)	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Circulation Problems	☐Yes ☐No	Jaundice	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cold Sores	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Ulcer	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Leukemia	☐Yes ☐No	Sexually Transmitted Disease	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Liver Disease	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Developmental Delay	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Weight Loss unexplained	☐Yes ☐No
Diabetes	☐Yes ☐No	Measles	☐Yes ☐No	Herpes	☐Yes ☐No
Down Syndrome	☐Yes ☐No	Mental Illness/Anxiety	☐Yes ☐No	Do you wear contact lenses?	☐Yes ☐No

Females:

Are you pregnant? ☐Yes ☐No Due Date:_____ Are you nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

Medication

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name: _____

Phone #: _____

Allergies

☐ Acrylic
☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Metal
☐ Penicillin
☐ Sulfa
☐ Other _____

Signature Parent/Legal Guardian _____ Date _____

Signature Doctor _____ Date _____

2017

Lindquist Dental Clinic for Children

Parkland * South Tacoma * Gig Harbor * Bremerton

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We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this anual patient information form as completely as you can. If you have questions we will be glad to help you. Wel look forward to working with you in maintining y7our child's dental health.

Date: _____

Name of Minor/Child _____ Nickname: _____

Sex ☐M ☐F Age _____ Birth Date _____ School _____

Phone Numbers ( ) —- ( ) —- ( ) —-
Cell Home/Secondary Work

Home Address _____
Address City State Zip Code

Mailing Address _____
Address City State Zip Code

Name of Parent/Guardian _____ Relation _____

Emergency Contact _____
Name Phone Relation

Email Address: _____

By providing your email, you are giving LDCC permission to contact you via email. Contact will include, but is not limited to , appointment confirmations and reminders, treatment information, information regarding the clinics, LDCC newsletter, special events and other LDCC related communications. LDCC will not share your information.

How did you find out about LDCC? _____

In my absence, I give permission for the following adult(s) to bring my child to LDCC, make healthcare decisions, and provide consent for treatment. This aurhtorization is good for this calendar year.

_____ ( ) —-
Name Relation Telephone

_____ ( ) —-
Name Relation Telephone

_____ ( ) —-
Name Relation Telephone

Date of last visit to the dentist: _____ For what services: _____

IMPORTANT—PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Dental Insurance Informaiton

LDCC accepts WA Apple Health (Medicaid/Provider One), most private insurance and offers a sliding fee scale.
Please let us know which options apply to your child.

Please check and provide information for all that apply.

PRIMARY SECONARY

☐ ☐ **WA Apple Health (Provider One):** ____ ____ ____ ____ ____ ____ ____ ____ ____ WA

Please provide child's 9 digit number for the Provider One/WA State Service Card.

☐ **Primary Private Insurance:** Subscriber Name: _____ Subscriber DOB: ____/_____/_____

Subscriber ID # /or DOD#: _____ Group or Policy #: _____

Insurance Company: _____Insurance Company Address: _____

Employer Name: _____ Insurance Phone Number:_____

Subscriber Address:_____

☐ **Secondary Private Insurance:** Subscriber Name: _____ Subscriber DOB: ____/_____/_____

Subscriber ID # /or DOD#: _____ Group or Policy #: _____

Insurance Company: _____Insurance Company Address: _____

Employer Name: _____ Insurance Phone Number:_____

Subscriber Address:_____

☐ **Sliding Fee Scale:** I am interested in applying for Financial Assistance for services provided by LDCC. In order to receive Financial Assistance, a separate financial assistance application must be completed along with providing proof of household income on an annual basis.

We are plated that many of you have dental benefits and our office will assist you in obtaining the maximum benefits specified in your contract. Your benefits are a contract between you, your employer and a carrier. We will assist you in determining your benefits as best we can. Because plans differ from carrier to carrier and policy to policy, our office many refer you to your carrier or your employer's benefits coordinator for assistance in understand your plan. As a courtesy to you, we will file your benefits claim and accept assignment of benefits. Not all services are covered benefits in all contracts. Some carriers and employers select only some services to be covered. You are responsible for payment of all services regardless of the payable benefits.

INSURANCE AND FINANCIAL POLICY

I authorize Lindquist Dental Clinic for Children, or my insurance company, to release any information required for payment or review of any dental claims. I am financially responsible to Lindquist Dental Clinic for Children for all balances due and assign my benefits to Lindquist Dental Clinic for Children. My portion of pay and co-pay (the amount your insurance does not cover) or any amount my insurance does not cover, or total amount should I not have insurance, is due at the time of service unless other arrangements are made. I have read and understand this.

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TREATMENT CONSENT

I consent to the diagnostic procedures and treatment deem necessary to thoroughly diagnose the patient's dental needs. If the patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

Name: _____

Signature:_____Date: _____

Chart Number _____
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Policies Acknowledgement

Patient Information

Child's Name:

Last Name	First Name	Date of Birth

Policies

It is the goal of Lindquist Dental Clinic for Children to provide a positive dental experience for both the patient and the family.

WE REQUEST PARENTS/GUARDIANS AND SIBLINGS WITH SCHEDULED APPOINTMENTS REMAIN IN THE WAITING ROOM.

Cancellation and No-Show Policy
If you need to cancel or reschedule your appointment, you **we ask that you call our office by noon the day before your appointment**. If the clinic is not open the day before your appointment, please call and leave a voice mail message. Your child's appointment will be considered a "failed" appointment if we are not notified by noon the day prior to the appointment or if you no-show for your appointment. Patients with multiple failed appointments may lose ability to schedule during prime appointment times.

Late Arrival
A late arrival is arriving any time after your scheduled appointment. If you arrive late your appointment may have been filled by another patient. You will be offered to wait on a standby basis for an opening that day or reschedule your appointment.

Scheduling with Multiple Children
LDCC will schedule up to 3 children on the same day, with no more than 2 during the same time slot. Additional children will be scheduled for another day or may be seen on stand-by as schedule allows.

Payment & Late Fee Policy
If you have qualified for the sliding fee scale, a minimum payment of $20.00 or the balance due is expected at time of service.

DSHS patients must bring their Provider One card to insure current monthly eligibility.

Private insurance patients must bring proof of insurance and pay their portion at each appointment

Your family may qualify for financial assistance for your patient portion. To apply for financial assistance you must complete the financial assistance form and provide proof of income. The amount of assistance is based on family size and annual gross income. Financial assistance must be renewed each calendar year.

Parent/Legal Guardian _____ Date_____
Print name _____

Chart Number _____
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Photo Release

Patient Information

Child's Name:

_____ _____

Last Name First Name Date of Birth

I, as parent or legal guardian of the person named above, I authorize ***Lindquist Dental Clinic for Children (LDCC)*** to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, fundraising, marketing, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting record(s)) for teaching purpose, to illustrate scientific papers or lectures, marketing or fundraising at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applies. I hereby consent to any or all of the above procedures and understand that the resulting media may be used on television, in print and online. LDCC shall own all rights, titles and interests, including the copyright, in and to the media, including the media and related materials, to be used and disposed of, without limitation, as LDCC shall in LDCC's sole discretion determine.

Parent/Legal Guardian _____ Date _____

Print Name _____

Chart Number _____
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Acknowledgement of Receipt of Notice

Patient Information

Child's Name:

Last Name	First Name	Date of Birth

I give this practice/clinic my consent to use or disclose my child's protected health information to carry out their treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have reviewed Lindquist Dental Clinic for Children's "*NOTICE OF PRIVACY PRACTICES"* before signing this consent.

I understand that Lindquist Dental Clinic for Children has the right to change their privacy practice and that I may obtain any revised notice at Lindquist Dental Clinic for Children.

I understand that I have the right to request a restriction of how my child's protected health information is used. However, I also understand that Lindquist Dental Clinic for Children is not required to agree to the request. If Lindquist Dental Clinic for Children agrees to my request, they must follow the restriction(s) I have submitted in writing.

I also understand that I may revoke this consent at any time, by making a request in writing except for information already used or disclosed.

Parent/Legal Guardian _____ Date _____