



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 phentermine), Pandimin (fenfluramine)

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

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

- Acrylic
 Aspirin
 Barbiturates (Sleeping Pills)
 Codeine
 Iodine
 Latex

Allergies

- Local Anesthetic
 Metal
 Penicillin
 Sulfa
 Other _____

Pharmacy Name: _____

Phone #: _____

Signature Parent/Legal Guardian _____

Date _____

Signature Doctor _____

Date _____



2017

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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 annual patient information form as completely as you can. If you have questions we will be glad to help you.

We look forward to working with you in order to maintain your child's dental health.

Thank you!

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: _____ Relationship: _____

Emergency Contact: _____
Name Phone Relationship

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 authorization is good for this calendar year.

_____	_____	() —
Name	Relationship	Telephone
_____	_____	() —
Name	Relationship	Telephone
_____	_____	() —
Name	Relationship	Telephone

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

IMPORTANT—PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Dental Insurance Information

LDCC accepts WA Apple Health (Medicaid/Provider One), most private insurances, and offers a sliding fee scale. Below please indicate which option(s) apply to your child.

Please check and provide information for all that apply.

PRIMARY

SECONDARY

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 #: _____

Subscriber Address: _____

Insurance Company: _____ Insurance Company Address: _____

Employer Name: _____ Insurance Phone Number: _____

Secondary

Private Insurance:

Subscriber Name: _____

Subscriber DOB: ____/____/____

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

Subscriber Address: _____

Insurance Company: _____ Insurance Company Address: _____

Employer Name: _____ Insurance Phone Number: _____

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 pleased 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/or 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 may refer you to your carrier or your employer's benefits coordinator for assistance in understanding 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.

TREATMENT CONSENT

I consent to the diagnostic procedures and treatment(s) deemed 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: _____



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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 _____



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Photo Release

Patient Information

Child's Name:

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 _____



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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