Chart Number __________
(for internal use only)

2019
Lindquist Dental Clinic for Children

Parkland * South Tacoma * Gig Harbor * Bremerton

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 many 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: ____________________