Apple Pediatric Dentistry

Dr. Edward Chin, DDS, MS | Dr. Laura Stewart, DDS | Dr. Rosemary Chen, DMD
Bellingham | Stanwood | Ferndale

Patient information

Child's name OR you (if over the age of 18):_____

Sex: **M** **F** Birth Date_____ Child's first dental visit? **Y** **N** Date of last visit_____

Previous Dentist_____ Is your child adopted/foster? **Y** **N** **LEGAL** guardian:_____

How did you hear about our office?_____

Is your child OR you (if over the age of 18) covered by DSHS? **Y** **N** ProviderOne number:_____

***Please request a separate form for private insurance**

Medical information

Primary physician's name_____ Phone_____

Is your child/you taking any medication? **Y** **N** Please list:_____

Has your child ever been hospitalized? **Y** **N** When?_____ Reason:_____

Does your child have any emotional/sensory issues? **Y** **N** Please elaborate:_____

Allergies? **Y** **N** Please list:_____

Has your child had a history or difficulty with any of the following? PLEASE CHECK ALL THAT APPLY

- ☐ **Heart murmur**
- ☐ **Leukemia**
- ☐ **Rheumatic fever**
- ☐ **Surgeries/operations**
- ☐ **High/low blood pressure**
- ☐ **Artificial bones/joints/Implants**
- ☐ **Tonsillitis**
- ☐ **Tuberculosis**
- ☐ **Artificial heart valves**
- ☐ **HIV/AIDS/ARC**
- ☐ **Chemotherapy**
- ☐ **Seizures/Epilepsy**
- ☐ **Cerebral palsy**
- ☐ **Diabetes/Hypoglycemia**
- ☐ **Hepatitis**
- ☐ **Anemia**
- ☐ **Hyperactive/ADD**
- ☐ **Scarlet fever**
- ☐ **Asthma/respiratory problems**
- ☐ **Congenital heart defect**
- ☐ **Hemophilia/Abnormal bleeding**
- ☐ **Speech/Vision/Hearing problems**
- ☐ **Cancer/tumors**
- ☐ **Organ problems**

Dental information

Was your child bottle fed? **Y** **N** Until what age?_____ Was your child breastfed? **Y** **N** Until what age?_____

Does your child have any mouth habits, such as: finger, thumb sucking, pacifier, etc.? **Y** **N**

Has your child ever had any injuries to his teeth, mouth or head? **Y** **N** When?_____ Details_____

Does your child brush and floss regularly? **Y** **N** Does an adult assist with brushing and flossing? **Y** **N**

Comments/details:_____
_____

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Family information

Parent, foster or legal guardian (you, if over the age of 18):

***Please note: this will be the patient's responsible party**

First name: _____ Last name: _____ Middle initial: _____

Date of birth: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Social security number (this is used for billing and insurance purposes only):_____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Employer/occupation: _____

***Would you like to receive text messages as reminders for your appointments? Y N**

Second parent, foster, or legal guardian:

First name: _____ Last name: _____ Middle initial: _____

Date of birth: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Social security number (this is used for billing and insurance purposes only):_____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Employer/occupation: _____

Authorization

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Apple Pediatric Dentistry and to consent for any and all recommended dental services:

Authorized person(s)	Relationship to child	Contact number
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Consent for services

1. **I authorize** the Dentist(s) and its designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the Dentist(s) to make a thorough diagnosis of my/child's dental needs.
2. **I authorize** the Dentist(s) to perform all recommended treatment and to use traditional behavioral management techniques for myself/my child and to employ such assistance as required in which to provide clinical care safely and comfortably for both the patient and clinical staff.
3. **I authorize** the Dentist(s) to use dental materials that are approved by the American Dental Association and at the Dentist's discretion; to use dental materials that he/she feels will provide the best clinical results.
4. **I authorize** the Dentist(s) to release relevant information necessary to my insurance company(s) to assist in processing any dental insurance claims.

Broken appointment policy: "I am aware that Apple Pediatric Dentistry LLC requires 48 business hours advance notice to change or reschedule an appointment, with exception to individual circumstances. Saturday and Sunday are not considered business days for Apple Pediatric Dentistry, I must give notice on the Friday before an appointment that is scheduled the following Monday. I understand I will be charged $30.00 for any missed or broken appointments. Apple Pediatric Dentistry LLC. reserves the right to cancel and/or reschedule patients who may be late – if it is unlikely that we will be able to accommodate you/your child on that day."

***Please note: The $30.00 fee is not a billable insurance benefit. For our patients who are insured through the DSHS (i.e. Medicaid) program, Molina, Washington Apple Health, Provider One, Community Health or other governmental administered dental insurance plans, immediate dismissal from our patient roster will be enforced.**

Financial responsibility

All payments are due at the time of service. We understand that insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is contract between you and your insurance company; therefore, all charges are your responsibility. **All balances to be paid in full within 90 days after services are rendered, ask our receptionist about payment options and financial agreement contract. *Please note: returned checked fee is $30.00**

1. I am financially responsible for all collection costs incurred by the dental office regardless of insurance coverage. I am aware past due accounts are subject to an interest charge
2. The above information and certify that these forms were completed to the best of my knowledge.
3. It is my responsibility to inform Apple Pediatric Dentistry LLC of any changes to the information that I have provided at this or any previous visits.
4. Apple Pediatric Dentistry LLC takes no responsibility for verifying insurance eligibility or coverage details prior to each dental appointment.

"I acknowledge and agree to the office and financial policies above and to the privacy of information mandated by State and Federal Law."

Responsible party signature: _____ **Date:** _____

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Notice of privacy practices

This notice describes how health information about you may be used and disclosed.
Please review it carefully. The privacy of your health is important to us.

Our Legal Duty : We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. At the time of your records appointment you will be asked to sign the form stating you acknowledge this information. For additional copies of this Notice, please ask for a copy at the reception desk.

Uses & Disclosures of health information: We use and disclose health information about you for treatment, payment, and healthcare operations. For example: **Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. **Payment**: We may use and disclose your health information to obtain payment for services we provide to you **Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. **To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. **Persons Involved in Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. **Required by Law**: We may use or disclose your health information when we are required to do so by law. **Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. **Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights: **Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in photocopy format. **Disclosure Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. **Restriction**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. **Amendment**: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions & Complaints: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us in person or in writing. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. This Notice was adapted from the American Dental Association with permission.

"I have reviewed this notice and believe I understand my right to privacy."

Responsible Party (Print) : _____ Signature: _____ Date: _____