246 N. Mission Street • Wenatchee • WA • 98801 • (509) 664-5000

CHILD'S FULL NAME ______________________ Preferred Name ______________

❑ Male ❑ Female Birthdate __________ Age ____

School ______________ Number of children in family ____

❑ **Stepfather** ❑ **Guardian**

FATHER'S NAME ______________ Birthdate ___/___/___ Social Security No. ___-___-___

Mailing Address ______________________ Home Phone ______________

City ______________ State ______________ Zip Code ______________

Father's Occupation ______________ Employer ______________ Work Phone ______________

Cell Phone ______________ Best Contact# ______________ Email ______________

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ **Stepmother** ❑ **Guardian**

MOTHER'S NAME ______________ Birthdate ___/___/___ Social Security No. ___-___-___

Mailing Address ______________________ Home Phone ______________

City ______________ State ______________ Zip Code ______________

Mother's Occupation ______________ Employer ______________ Work Phone ______________

Cell Phone ______________ Best Contact# ______________ Email ______________

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

***With whom does this child reside?*** ______________________

Email Address ______________________

| PRIMARY DENTAL INSURANCE | SECONDARY DENTAL INSURANCE |
|---|---|
| Employee ______________ | Employee ______________ |
| Relationship to Patient ______________ | Relationship to Patient ______________ |
| Employer ______________ | Employer ______________ |
| Insurance Co. __________ Group # ______ | Insurance Co. __________ Group # ______ |
| Insured Birthdate ___/___/___ | Insured Birthdate ___/___/___ |
| Employee's S.S. No. ___-___-___ | Employee's S.S. No. ___-___-___ |

❑ No dental insurance

**Person financially responsible for child's account:** ______________________

* * * * * *

**IN CASE OF EMERGENCY, OTHER THAN THOSE LISTED ABOVE WHOM MAY WE CONTACT?**

Name ______________________ Home Phone ______________ Work Phone ______________

Relationship to Patient ______________

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Please answer all questions, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. *Thank You*.

## MEDICAL HISTORY

Is your child presently under the care of a physician?.......... ❑ Yes ❑ No
If so, for what condition? ________________________

Child's Physician ________________ Office Name ________________ Phone ________________
Date of last physical exam ________________ Findings ________________
Former Dentist ________________ Office Name ________________ Phone ________________

Is your child:

In good health?.......... ❑ Yes ❑ No

Sensitive or allergic to any medications or latex?.......... ❑ Yes ❑ No
If yes, please list: ________________________

Taking any medications?.......... ❑ Yes ❑ No
If yes, please list: ________________________

Has your child ever had any surgeries?.......... ❑ Yes ❑ No
If yes, please list: ________________________

### Does your child have any history of the following conditions (please circle):

| | | | |
|---|---|---|---|
| Asthma | Diabetes | Liver Disease | Hearing Difficulty |
| Bleeding Problem | Thyroid Problem | Kidney Disease | Speech Delay |
| Blood Transfusion | Seizure or Epilepsy | Tuberculosis (TB) | Development Delay |
| Heart Problem | Motor or Muscle Disorder | HIV/AIDS | Psychiatric Problem |
| Heart Murmur | Fainting or Dizziness | Autistic | ADD / ADHD |

Does your child have any other Problems, Conditions or Special Needs?
________________________

Has your child had any history of thumb sucking, lip biting? (If yes, circle condition).......... ❑ Yes ❑ No
Is your child taking fluoride pills or drops?.......... ❑ Yes ❑ No
Is your child in any contact sports?.......... ❑ Yes ❑ No
Has your child ever had an orthodontic evaluation or treatment (braces)?.......... ❑ Yes ❑ No
Name of Orthodontist ________________________
Is there any other information which will assist us in providing the best possible care for your child?
Please state here ________________________
Were you referred to our office?.......... ❑ Yes ❑ No
If so, whom may we thank ________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Drs. Ping & Dela Cruz and/or dental staff to perform the necessary dental services my child may need. This may include exams, radiographs, cleanings, topical fluoride treatment, restorative dentistry, oral surgery or limited orthodontics. In order to perform such treatment, our team may recommend the use of local anesthesia (numbing) and/or nitrous oxide (laughing gas).

Parent/Guardian Signature ________________________ Date ____/____/____
Dentist Signature ________________________

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*Effective date of notice: 12/1/09*

# NOTICE OF PRIVACY PRACTICES

Wenatchee Pediatric Dentistry
246 N. Mission Street
Wenatchee, WA 98801
(509)664-5000

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep your child's identifying health information private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your child's health information and what rights you have regarding your child's health information. Our practice reserves the right to change the terms of this notice and make the new terms effective for all protected health information that we maintain. Updates to this policy will be available to all patients upon request.

## TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your child's health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for your child; examining your child's teeth; prescribing medications and faxing them to a pharmacy; referring your child to another doctor for other health care services; or getting copies of your child's health information from another professional that they may have seen before us. Examples of how we use or disclose your child's health information for payment purposes are: asking about your child's health or dental care plan or other sources of payment; preparing and sending bills or claims; collecting unpaid amounts ("collections"). "Health care operations" mean those administrative and managerial functions that are necessary to run our office. Examples of how we use or disclose your child's health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your child's health information inside our office for these purposes discussed above without any special permission. If we need to disclose your health information outside of our office for these reasons, we will usually not ask for special written permission. We will ask for special written permission when requests are made for transferring records to another office.

## USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your child's health information without your permission. Not all of these situations will apply to us. Such disclosures are:

- When state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs/med devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, for audits by Medicaid, or for investigation of possible violations of health care laws.
- Disclosures for Judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.

- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened elsewhere.
- Disclosure to a medical examiner to identify a deceased person, or to determine cause of death; or funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president; for lawful national intelligence; for military purposes, or evaluation of members of foreign service.
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your child's care with your family or friends who are helping you with your child's dental care.

**APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments available at our office that may help your child. Unless you tell us otherwise, we may mail you an appointment reminder on a post card, and/or leave you a reminder message on your phone or with someone who answers your phone if you are unavailable.

**OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your child's health information unless you sign a written "authorization form". If we initiate the process, you are not obligated to sign the authorization form.

**YOUR RIGHTS REGARDING YOUR CHILD'S HEALTH INFORMATION**

The law gives you many rights regarding your child's health information, including:

- Ask us to restrict our uses and disclosures for purposes of treatment, payment, or health care operations.
- Ask us to communicate in a confidential way, such as using alternate mailing address or phone numbers
- Ask to see or obtain copies of your child's health information. Allow up to 30 days for processing such requests.
- Obtain a list of disclosures we have made within the past six years (fee may apply)
- Obtain additional paper copies of this Notice of Privacy Practices.

## Questions and Complaints

If you want more information, or have questions or concerns, please contact us.

**Wenatchee Pediatric Dentistry**

Privacy Officer: Chelsea

Address: 246 N. Mission St<br>Wenatchee WA 98801

Phone: 509-664-5000

Fax: 509-664-5001

# OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

## COMPLAINTS

If you think that we have not properly respected the privacy of your child's health information, you are free to file a complaint with us or the U.S. Department of Health and Human Services, Office for Civil Rights. If you wish to file a complaint, send a written complaint to the office contact person at the address, fax or Email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

## Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

Signature_________________________________________________ Date: _____________