721 N Pines Rd Suite 101
Spokane, WA 99206
509-926-1234 Phone
509-926-1701 Fax
smileoffice@kidsmiledental.com

Records Release Consent Form

Re: Record for _____
Patient's name

I,_____ authorize KidSmile Dental,
Signature of parent or legal guardian

To release a copy of protected health information to:

Name _____

Address _____

Email_____

Reason for request:
Transfer _____ Other_____
I understand that I have the right to revoke this authorization at any time by sending written notification to KidSmile Dental. I understand that information used pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal law (such as to an oral surgeon or orthodontist, or other professionals when requested).

I understand that I have the right to:
-Inspect or copy my protected health information to be disclosed as permitted under federal or state law.
- Refuse to sign this authorization.

_____

Print your name and relationship to patient date

KIDSMILE DENTAL

FINANCIAL POLICY

Welcome to our practice. We are committed to providing you with the best possible dental care. It is our goal for our patients and families to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make your dental treatment affordable for you.

We ask that the parent bringing in a child pay for all treatment and/or co-insurance amounts at the time of treatment regardless of custody agreements.

We accept the following methods of payment

1. **CASH ACCOUNTS**: We offer a 5% discount. Payment in full is due on the day of service. Any payment arrangements need to be made with our financial coordinator prior to your appointment date. There is a fee for returned checks.
2. **CREDIT CARD**: MasterCard, VISA, American Express and CareCredit
3. **DSHS Medicaid**: with a valid Medicaid I.D. card
4. **DENTAL INSURANCE**

A word about dental insurance...

We are pleased you have dental insurance. However, it is important to realize that:
Your policy is a contract between you/your spouse's employer and the insurance company. We are not a party to that contract.

Not all services are covered in all contracts. Some insurance companies exclude or limit certain services. The best way to take advantage of your plan is to understand the scope and limitations of your dental policy.

We ask that you provide us with current and accurate insurance and employment information at the time of your appointment.

We will bill your insurance company for dental treatment as a courtesy. Our courtesy service includes

1. Filing your claim electronically within 24 hours of your visit for short turn around time.
2. If your claim is unpaid, we will file a second time within 60 days.

If your insurance does not pay us within 60 days of your appointment, the entire balance is due from you. We will then direct your insurance company to reimburse you directly.

Agreement:

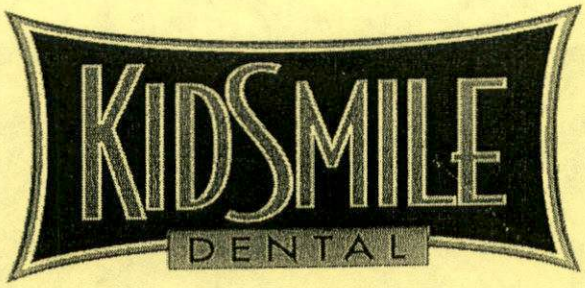
I request and authorize KidSmile Dental to provide my child with dental care. I understand I am personally responsible for the charges for the services I receive.

I agree to make full payment for services I receive. I understand that regardless of dental insurance benefits, any treatment I receive is my financial responsibility.
I agree to pay all reasonable attorney fees and costs of collection incurred by KidSmile Dental if my account is not paid as agreed. In addition, I understand that I will be asked to seek dental care elsewhere.
I understand that where appropriate, Credit Bureau Reports may be obtained.

Your name please print)_____Signature_____

Patient's name_____Date_____

The laws of Washington State shall govern this agreement. In the event of a lawsuit regarding this agreement, the venue shall be proper only in Spokane County, Washington.



NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide your child. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your child's record or get more information about it by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your child's health information may be used and disclosed, and how you can access that information

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Parent or legally authorized individual signature Date Time

_____ _____

Print your name Relationship (parent, legal guardian, Personal representative

Child's Name_____

This form will be retained in your child's record.

KIDSMILE DENTAL

OFFICE POLICY REGARDING SCHEDULED APPOINTMENTS

Our office has guidelines we feel are essential for the successful and continued treatment of your child. We look forward to providing years of dental care for your child and encourage your cooperation and support.

We ask that at least 24 hours notice be given to our office if you must cancel or reschedule an appointment. This will allow us adequate time to schedule another child who may be waiting for dental care. You may be asked to seek care elsewhere after two missed appointments.

Please be on time for your appointment. It is our goal to see each child as promptly as possible. However, due to emergencies occasionally you may need to wait a short time. We ask for your patience if this occurs. If you have waited more than 15 minutes, please mention it to our receptionists.

Most children do very well on their own. We ask that you encourage your child to be seated in the clinic without you present. This allows us the opportunity to establish a good relationship and effective communication with your child. You will be invited to join your child during the dentist's examination.

Nitrous Oxide ('Laughing gas') is a mild relaxant commonly used to relieve anxiety during dental appointments. It is only recommended when our dentist believes it is in your child's best interest. It is important that dental visits be as pleasant as possible.

Please feel free to ask any questions you may have regarding our policies.

I have read and understand the office policies and agree to comply with the guidelines on this page.

Name_____Date_____

Welcome to KidSmile Dental where our focus is on the family. With a passion for children, the dentists and staff here at KidSmile are here to create a relaxed and effective environment to meet all of your children's dental needs. We keep you informed, and your children smiling with good dental health and a positive experience every time.

TELL US ABOUT YOUR CHILD

Child's Name:			Today's Date:
Nickname:	Age:		Sex:
Child's Birthdate:	School:		Grade:
Child's Home Address:	CITY:	STATE:	ZIP CODE:
Name/Age of Siblings:			Home Phone:
Previous Dentist:			Last Visit Date:
Who may we thank for referring you?:			
EMERGENCY CONTACT (Nearest friend or relative not living with you)			
Name:	Relationship:	WK#:	HM#:

MOTHERS INFORMATION

Stepmother___ Guardian___

Name:			
Address:	City:	State:	Zipcode:
Email:	Cell:	WK#:	HM#:
Employer:		Occupation:	
Birthdate:		SS#:	

FATHERS INFORMATION

Stepfather___ Guardian___

Name:			
Address:	City:	State:	Zipcode:
Email:	Cell:	WK#:	HM#:
Employer:		Occupation:	
Birthdate:		SS#:	
Person Responsible for Account:		Relation:	
Billing Address (if different from patient):			
City:	State:	Zipcode:	

PRIMARY DENTAL INSURANCE

Insurance Co. Name:	Insurance Address:
Insurance Phone:	ID#:
Group# (Plan, Local or Policy#):	Insured's Name:
Relationship to Patient:	Insured's Birthdate:
Insured's SS#	Insured's Employer:

SECONDARY DENTAL INSURANCE

Insurance Co. Name:	Insurance Address:
Insurance Phone:	ID#:
Group# (Plan, Local or Policy#):	Insured's Name:
Relationship to Patient:	Insured's Birthdate:
Insured's SS#	Insured's Employer:

I hereby authorize payment to KidSmile Dental any insurance benefits otherwise payable to me. I authorize the doctors to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is true and correct to the best of my knowledge.

Signature _____ Date _____

Patient Health Information

Patient's Name_____ Date_____

	YES	NO
Is your child currently under the care of a physician?	❑	❑

If yes, Why?_____

Child's Physician: _____

Phone #:_____ Last Visit: _____

Has your child ever had general anesthesia or sedation?

If yes, when:_____

Were there any complications: _____

Please describe the child's health: Good Fair Poor

Is your child allergic to anything?

IF YES, WHAT:_____

_____

Please list all drugs the child is currently taking: _____

_____

_____

Does your child require antibiotics prior to invasive dental procedures? YES NO

If yes, please explain:_____

Has the child been diagnosed or treated for any of the following conditions:

Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Gastrointestinal (stomach)	❑	❑	Scoliosis
❑	❑	Arthritis	❑	❑	Hearing Loss	❑	❑	Sickle Cell Anemia
❑	❑	Asthma	❑	❑	Heart Disease	❑	❑	Sinus Problems
❑	❑	Autism	❑	❑	Heart Murmur	❑	❑	Snoring at Night
❑	❑	Bronchitis	❑	❑	Hemophilia	❑	❑	Sore Throat - Frequent
❑	❑	Cancer	❑	❑	Hepatitis - Type_____	❑	❑	Spina Bifida
❑	❑	Cerebral Palsy	❑	❑	Immunodeficiency	❑	❑	Syndrome
❑	❑	Cleft Lip / Palate	❑	❑	Leukemia	❑	❑	IF YES, WHAT:_____
❑	❑	Convulsions / Seizures	❑	❑	Measles / Mumps			_____
❑	❑	Developmentally Delayed	❑	❑	Mouth Breathing	❑	❑	Tetanus
❑	❑	Diabetes	❑	❑	Nutritional Deficiency	❑	❑	Tonsils / Adenoids
❑	❑	Epilepsy	❑	❑	Orthopedic Problems	❑	❑	Tuberculosis
❑	❑	Eye Problems	❑	❑	Pneumonia	❑	❑	Whooping Cough
❑	❑	Excessive Bleeding	❑	❑	Polio	❑	❑	Other_____
❑	❑	Fainting	❑	❑	Psychiatric Disorder			_____
			❑	❑	Rheumatic / Scarlet Fever			_____

Is there anything else you think we should know about your child?_____

Has your child been seen by a dentist before? Y N Date last seen_____ Name of Dentist _____

Has your child ever had a serious/difficult problem associated with dental work? Y N

Please explain:_____

_____

At what age did your child stop bottle/breast feeding? _____ Is the child's water fluoridated? Y N Unknown

Is the child taking any fluoride supplements? Y N Does the child suck his/her thumb or fingers or pacifier? Y N

Would you like to speak to the Doctor privately about any problem? Y N

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of person completing this form: _____ Date:_____

Relationship to patient:_____

Dentist's Signature: _____ Date:_____