WELCOME

1 About Your Child

Today's Date: ____/____/____ File #:_____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home Phone #:(_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ _____
MOTHER'S SOCIAL SECURITY # MOTHER'S DRIVERS LIC. #

Employer: _____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ _____
FATHER'S SOCIAL SECURITY # FATHER'S DRIVERS LIC. #

Employer: _____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

_____ _____
SOCIAL SECURITY # DRIVERS LIC. #

Work Phone #:(_____)_____

Payment method: ❑ Cash ❑ Check

_____ /_____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw.	❑ Lost/Broken Filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums.	❑ Teeth grinding	❑ Locking Jaw
❑ Sensitive tooth, teeth or gums.	❑ Ringing in Ears	❑ Bad breath
❑ Blisters/Sores in or around the mouth.	❑ Broken/Chipped tooth	❑ Loose tooth

❑ Other(s): _____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (_____) _____

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? 1 2 3 4 5 6 7 8 9 10

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others: _____

Child's Physician: _____ (_____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases or medical conditions?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Difficulty Breathing	**Y N** Organ Problems
Y N Scarlet Fever	**Y N** Leukemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Anemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Diabetes/Hypoglycemia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Hemophilia	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Abnormal Bleeding	**Y N** Fainting/Seizures/Epilepsy

Please list any other medical condition(s) child has or ever had: _____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine) ❑ Aspirin ❑ Food allergies ❑ Other(s): _____

Please rate the child's general health from 1-10: _____ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long? _____ Child's Blood type: _____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking ❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____
❑ Parent or Guardian ❑ Other:

UPDATE (OFFICE USE)

Initials ____ Date ____ / ____ / ____
Comments

Initials ____ Date ____ / ____ / ____
Comments

Initials ____ Date ____ / ____ / ____
Comments

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Brian K Filbert, DDS
33507 9th Ave. S., Bldg B, Suite 1
Federal Way, WA 98003
253-838-5474

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

BRIAN K FILBERT, DDS
33507 9TH Ave S., Bldg B, Suite 1
Federal Way, WA 98003
253-838-5474 or 253-927-3429

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

__ **Payment by cash**

__ **Payment by check**

__**Payment by credit card #**_____ **, Expires**_____

__ **Automatic monthly billing to your Credit Card**

#_____**, Expires**_____

__ **Guarantee any amount not covered by insurance with your credit card**

#_____**, Expires**_____

Care Credit and Springstone Financing options available, applications in office.

Make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your credit card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis

By signing, you also acknowledge, we do require 2 business days cancellation notice, or a fee of $50- per hour may be charged to your account.

_____

Please print name and signature

Date:_____