SPOKANE PEDIATRIC DENTISTRY PATIENT REGISTRATION

Spokane Pediatric Dentistry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spokane Pediatric Dentistry cumple con las leyes federales de derechos civiles aplicables y no discrimina. por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

PATIENT INFORMATION

First Name:		Middle Initial:
Last Name:		Preferred/Nickname:
Address:		
City:	State:	Zip:
Sex:	Birthdate:	Race:
Preferred Language:		How did you hear about us?

PARENT/LEGAL GUARDIAN INFORMATION

Guardian (1) Name:	Guardian(1) Address: (if different from patient)
Guardian (1) SSN:	Guardian(1) DOB: (MM/DD/YYYY)
Guardian (1) Relationship to patient: ☐Mother ☐Father ☐Other:_____	Guardian (1) Employer:
Contact Phone #1: ☐Home ☐Mobile ☐Work	Contact Phone #2: ☐Home ☐Mobile ☐Work
Email:	

Guardian (2) Name:	Guardian (2) Address: (if different from patient)
Guardian (2) SSN:	Guardian (2) DOB: (MM/DD/YYYY)
Guardian (2) Relationship to patient: ☐Mother ☐Father ☐Other:_____	Guardian (2)Employer:
Contact Phone #1: ☐Home ☐Mobile ☐Work	Contact Phone #2: ☐Home ☐Mobile ☐Work
Email:	

Who has legal custody of patient? ☐**Guardian 1 & 2** ☐**Guardian 1** ☐**Guardian 2** ☐**Other:** _____

Emergency Contact:	**Relation to patient:**	**Emergency Contact Phone:**

INSURANCE INFORMATION

Primary Dental Insurance Co:

Name of Subscriber:	Relationship to Child:
Subscriber Address:	
Subscriber DOB: (MM/DD/YYYY)	Subscriber SSN:
Subscriber Phone:	Policy #:
Group #:	Subscriber Employer:

Secondary Dental Insurance Co:

Name of Subscriber:	Relationship to Child:
Subscriber Address:	
Subscriber DOB: (MM/DD/YYYY)	Subscriber SSN:
Subscriber Phone:	Policy #:
Group #:	Subscriber Employer:

Spokane Pediatric Dentistry
PATRICK BRADLEY, DDS

MEDICAL HISTORY

Child's Pediatrician/Office Name_____ Approx Date of last exam_____
Has your child ever been admitted to the hospital or had surgery? ☐*Yes* ☐*No*
If yes please list_____
Does your child have any allergies? ☐*Yes* ☐*No* *If yes, please check all that apply:*
☐*Food* *Specify:*_____
☐*Medications* *Specify:* _____
☐*Latex*
☐*Local Anesthetics* *Specify:* _____
☐*Other*_____
Does your child take any medications? Please list: _____
Does your child have a history of any of the following conditions? *Check all that apply:*

☐*Asthma*	☐*Heart murmur*	☐*Fainting or Dizziness*	☐*Speech delay*
☐*Autism*	☐*Diabetes*	☐*Liver Disease*	☐*Developmental Delay*
☐*Bleeding problems*	☐*Thyroid Problems*	☐*Kidney Disease*	☐*Psychiatric Problems*
☐*Blood transfusions*	☐*Seizures or epilepsy*	☐*Tuberculosis*	☐*ADD/ADHD*
☐*Heart conditions*	☐*Muscular Disorder*	☐*HIV/Aids*	

☐*Other Condition(s):*_____
Please list any special needs or concerns regarding your child:
_____
Is your child up to date with immunizations? ☐Yes ☐No

DENTAL HISTORY

Is this your child's first dental visit? ☐*Yes* ☐*No*
Previous dentist? _____ Approx. date of last dental visit? _____
Has your child had previous dental trauma? ☐*Yes* ☐*No*
If yes, please explain _____
Has your child had previous bad experiences at the dentist? ☐*Yes* ☐*No*
If yes, please explain _____
Is your child taking fluoride products? ☐*Toothpaste* ☐*Drops* ☐*Tabs* ☐*Water* ☐*None*
Does your child have any oral habits? ☐*Thumb habit* ☐*Tongue thrust* ☐*Lip biting* ☐*Grinding*
Has your child had any of the following before? ☐*Cavities* ☐*Fillings* ☐*Crowns* ☐*Extractions*
Does your child participate in contact sports? ☐*Yes* ☐*No*
Has your child had an orthodontic evaluation or treatment? ☐*Yes* ☐*No*
Name of orthodontist? _____

Preferred pharmacy? _____

Is there any other information that you that you feel would be helpful for in providing care?
_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature Legal Guardian: _____ Date: _____

Relationship to Patient: _____

Spokane Pediatric Dentistry
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CONSENT AND PRIVACY STATEMENT

I, _____, attest that I am the legal guardian of the below listed names and authorize Dr. Patrick Bradley, DDS and any associated dentist, hygienist, or assistant to provide routine and emergency dental care for my child/children,

_____.

LIST EACH CHILD'S NAME

PLEASE INITIAL EACH PARAGRAPH:

- Authorization is given for: examinations, X-Rays, cleanings, fluoride, administration of local anesthetic and nitrous oxide (laughing gas), and routine restorative treatment, including: fillings, crowns, pulpal therapy, space maintenance and primary tooth extractions. _____

- I understand the behavior of children in the dental office can be unpredictable and authorize Dr. Bradley and associates to employ the use of a mouth prop and brief periods of physical restraint***** to ensure the safety of my child. _____
  *(*Spokane Pediatric Dentistry will **never**, use "mechanical restraints" in the forms of papoose boards, pedi-wraps, tape, straps, etc.)*

- I understand the Notice of Privacy Practices is available to me by request. I understand this policy describes the types of uses and disclosures of my protected health information that may occur in relation to treatment, referrals, payments or other health care operations. I also understand this policy details my rights under The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). _____
  (Please notify Spokane Pediatric Dentistry if you would like a copy of the Notice of Privacy Practices for your records.)

- I authorize my pediatrician and/or other physicians/medical facilities to release any and all pertinent medical information/records regarding my child and give Spokane Pediatric Dentistry permission to release medical information/records to other physicians/medical facilities if needed. _____

Legal Guardian Name: _____ Date: _____

Signed: _____ Relationship to patient(s): _____

NON-PARENT(S) PERMITTED TO BRING CHILD

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for their routine dental appointment(s):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

By providing Spokane Pediatric Dentistry with the above names of individuals allowed to escort my child to their routine dental appointments, I understand that being the patient(s) legal guardian, ***the above named individual(s) cannot sign any consent for treatment/anesthesia and I (the legal guardian) must sign any consent prior to treatment and be present for general anesthesia procedures.***

Legal Guardian Name: _____ Date: _____

Signed: _____ Relationship to patient(s): _____

Spokane Pediatric Dentistry
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INSURANCE AND APPOINTMENT POLICIES

INSURANCE POLICY: In an effort to keep costs down while maintaining a high level of professional care, we file insurance claims as a courtesy to our patients provided you agree to the following:

- You must provide us with an insurance card and all necessary information to verify your child's coverage to file your claim.
- Patients with insurance will be required to pay, at time of service all estimated patient portions. This payment is an **estimate** by our office based on your insurance benefits. We are not responsible for its accuracy. **Knowledge of benefits, limitations, exclusions, etc. is ultimately your responsibility.** Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- You are responsible for deductibles, co-payments, coinsurance, and any balance remaining in your account not covered by insurance.
- Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. All dispute resolutions will be with your insurance company.
- After dental insurance has paid its portion, a statement will be sent to the mailing address on record for remaining balance.

PAYMENT/FEE POLICY: Payment is due at the time of service. Our office accepts cash, check, Visa, and MasterCard. **Any account which is past due more than 180 days is subject to dismissal of the family from the practice and subject to being referred to an attorney for collection.** Additional fees may be applied to your account as follows:

- $30 charge for all returned checks.
- 1.5% late fee each month on all outstanding balances 60-days past due.
- $40 missed/broken appointment (see definition of broken appointment below)
- Appliance Fee for no-show/broken appointment or broken appliance (dependent on the lab charge)

GENERAL ANESTHESIA – SURGICAL DEPOSITS POLICY: The patient's expected portion of charges (insurance and/or deductibles) will be collected the day of procedure.

GENERAL ANESTHESIA APPOINTMENTS – SURGICAL POLICY:

- **NO-SHOW TO GENERAL ANESTHESIA APPOINTMENT:** If you "no-show" to your child's scheduled GA appointment, depending on your insurance, you will be charged a fee $100.00 and this will result in the dismissal of your child and family from the practice.
- **IF YOU CANNOT ATTEND YOUR SCHEDULED GENERAL ANESTHESIA APPOINTMENT:** You must call to reschedule a minimum of one week (7 days, excluding holidays/weekends) in advance to cancel. If we do not have one week advance notice of cancellation, depending on your insurance, you will be charged a fee of $100.00**.** We will not reschedule the GA appointment until the fee is paid. This is considered a "broken" GA appointment. We will only reschedule your child's GA appointment one additional time after fee is paid. If a second "broken" GA appointment occurs, depending on your insurance, you will be charged a fee of $100.00 and the second "broken" GA appointment will result in the dismissal of your child and family from the practice.
- If we do not receive the required pre-surgical physical two weeks prior to your child's scheduled surgery, your child's appointment will be cancelled. It is your responsibility to call our office to get your child back on our schedule for surgery if this happens. Once scheduled for the second time, if you fail to get the required pre-surgical physical in to our office by the deadline, your family will be dismissed from the practice and treatment will not be rescheduled.
- We realize that sometimes illness can come on very quickly, so we ask that you contact us immediately and schedule your child for a wellness evaluation prior to the procedure.

ORAL SEDATION APPOINTMENTS POLICY:

- **NO-SHOW TO ORAL SEDATION APPOINTMENT:** If you "no-show" to your child's scheduled oral sedation appointment, depending on your insurance, you will be charged a fee $100.00 and this will result in the dismissal of your child and family from the practice.
- **IF YOU CANNOT ATTEND YOUR SCHEDULED ORAL SEDATION APPOINTMENT:** You must call to reschedule 3 days (72 hours, excluding holidays/weekends) in advance to cancel. If we do not have 3 day advance notice of cancellation, depending on your insurance, you will be charged a fee of $100.00**.** We will not reschedule the oral sedation appointment until the fee is paid. This is considered a "broken" appointment. We will only reschedule your child's oral sedation appointment one additional time after fee is paid. If a second "broken" oral sedation appointment occurs, depending on your insurance, you will be charged a fee of $100.00 and the second broken oral sedation appointment will result in the dismissal of your child and family from the practice.
- We realize that sometimes illness can come on very quickly, so we ask that you contact us immediately and schedule your child for a wellness evaluation prior to the procedure.

LATE ARRIVAL POLICY: If you arrive more than **15 minutes** late for your child's appointment, you will be asked to reschedule for the next available appointment time or day.

BROKEN & MISSED APPOINTMENT POLICY:

Your child's scheduled appointment is reserved specifically for them. We will remind patients by telephone prior to the appointment, but please do not solely rely on this courtesy. Our missed policy procedure is as follows:

- **No-showing to your scheduled appointment or appointments not cancelled with a 24 hours minimum advance will be considered a "broken appointment". If cancelling with less than 24 hour notice, your next appointment will be scheduled 6 weeks from the "broken appointment".**
- **You will be charged a fee of $40.00 (Depending on insurance) per child for any broken appointment. Your child's appointment will not be rescheduled until the fee is paid.**
- **If your child/children are scheduled at a peak time or day (Tuesdays 3pm-5pm, or anytime on Friday) in which a broken appointment occurs, we will no longer schedule you again on or at a peak time/day.**
- **If more than two broken appointments occur as a family, we will not reschedule the appointment and discontinue dental care for your child and family in the future.**

***AUTHORIZATION:**

I understand that I am responsible for the payment of all fees for dental treatment for the patient named. I understand that I am responsible for any fee not covered by the patient's dental or medical insurance. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Legal Guardian Signature: _____ **Date:** _____

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INFORMED CONSENT TO PHOTOGRAPH

Spokane Pediatric Dentistry is proud of your child for doing an outstanding job keeping their teeth clean and enjoys recognizing your child's accomplishments! In honor of your child, we would like to display his/her picture on our "Cavity-Free Tree", clinic brochures and/or clinic advertising, website, as well as our Spokane Pediatric Dentistry Facebook page. Spokane Pediatric Dentistry will protect the patient's personal data such as name, age, and date of birth, from being displayed.

I give consent to use my child's photograph on:

- ☐ Facebook/Instagram/Social Media Platforms
- ☐ "Cavity-Free Tree" (located in our hygiene bay in office)
- ☐ Spokane Pediatric Dentistry's website
- ☐ Clinic brochures, marketing materials
- ☐ I **do not** give consent to use my child's photograph for any of the above purposes.

Child/Children's Name: _____

Legal Guardian Name: _____

Legal Guardian Signature: _____