WELCOME, NEW PATIENT!

Patient's Name _____
Last First MI

Preferred/nickname _____ Date of Birth _____ Gender _____

Address _____ City _____ Zip _____

Primary Phone H/W/C _____ Alternate Phone H/W/C _____

_____ _____ _____
Name(s) of Legal Parent(s)/Guardian(s) Relationship to Patient Marital Status

Email Address _____

What is the reason for today's visit? _____

How did you hear about us? _____

When was the patient's last dental visit? _____ Were X-rays taken? YES NO

How was the patient's last dental experience? _____

HEALTH HISTORY

Patient's Physician's Name _____ Phone Number _____ Date of Last Exam _____

Is the patient in good health? If **NO,** please explain:	YES NO
Does the patient have any specific medical condition or diagnosis and/or under the care of a specialist? If **YES**, please explain:	YES NO
Have there been any changes in his/her health within the last year? If **YES,** please explain:	YES NO
Is the patient taking any medication, including non-prescription medication? **If YES, please complete below:** Medication: Dosage: Condition: Medication: Dosage: Condition:	YES NO
Does the patient have any **allergies** to food, drug, pets, or latex? **If YES, please explain:**	YES NO
Are immunizations up-to-date? If **NO,** please explain**:**	YES NO
Are there any issues with the ***heart*** (such as a congenital heart defect, surgery, murmur, or bleeding disorder). If **YES**, please explain:	YES NO
Are there any issues with the ***lungs*** (such as asthma or other breathing disorders)? If **YES,** please explain:	YES NO
Are there any issues with the ***ear***, ***nose***, or ***throat*** (such as enlarged tonsils, snoring/sleep apnea, speech delays, etc.)? If **YES,** please explain:	YES NO
Are there any issues with the ***stomach***, ***liver***, ***kidneys*** or other major ***organs***? If **YES,** please explain:	YES NO
Are there any ***skin*** issues (such as MRSA, eczema, or non-healing wounds)? If **YES,** please explain:	YES NO
Are there any ***eye*** issues (such as blindness or corrected vision)? If **YES,** please explain:	YES NO
Are there any issues with the ***muscles***, ***bones***, ***neurologic*** system or any type of ***genetic*** disorder? If **YES,** please explain:	YES NO
Are there any ***behavioral*** (such as ADD/ADHD or autism, etc.) or ***psychiatric*** issues (such as depression or bipolar disorder, etc)? If **YES,** please explain:	YES NO
Are there any issues with ***growth*** or ***development***? If **YES,** please explain:	YES NO
Was the patient born ***prematurely***? If **YES,** how early?	YES NO
Was the patient ***exposed*** to drugs or alcohol, ***in utero***?	YES NO
Has the patient had a serious illness; had surgery (including dental surgery); or hospitalized? If **YES,** please explain:	YES NO
Has the patient had any serious issues with previous dental treatment, surgery, anesthetic, or Nitrous Oxide (laughing gas)? If **YES,** please explain:	YES NO

If the patient has any **diseases/disorders, not mentioned** above, please describe it here: _____

Emergency Contact Information (other than yourself):

Name:_____ **Relationship to Patient:** _____ **Phone:** _____

I understand that withholding any information regarding this patient's health could seriously jeopardize his/her safety. Therefore, I have reviewed this health history carefully and thoroughly and have answered all questions truthfully, to the best of my knowledge.

X_____ _____

Signature of Parent or Legal Guardian **Date**

_____

Print Name of Parent or Legal Guardian

Office Use Only:

Patient's Weight:_____ Medical Health reviewed by:_____

Patient's Height:_____ Doctor's Signature and Date:_____

DENTAL AND SOCIAL HISTORY

Please answer the following questions:

Is this the patient's first dental visit? If NO, please provide the name of previous dentist, and date X-rays were taken, if applicable?	YES NO
What is the purpose of today's visit?	
Is the patient experiencing any **pain or discomfort?** If YES, please explain	YES NO
Is the patient taking **Fluoride** Supplements? If YES, who prescribed it?	YES NO
Who primarily brushes/flosses for the patient?	
What type of toothpaste does the patient use?	
How does the patient react to shots/vaccines?	
Has the patient ever experienced any problems or complications due to or during dental care? If YES, please explain:	YES NO
What are the patient's interests and hobbies?	
*Please circle **ALL** that apply:* **Breastfeeding Pacifier Bottle Sippy Cup Snoring Thumb-Sucking Teeth Grinding Lip Biting/Sucking**	
*Please circle **ALL** that apply:* **Outgoing Shy Stubborn Anxious Curious Defiant High-Strung Cooperative Angry Easy-going Happy**	

Insurance information

Primary

Policy Holder Name: _____ Date of Birth: _____SS#: _____

Patient's relationship to the insured: ___Self ___Child __Other:_____ Insurance Company:_____

Subscriber ID#_____ Group#_____ Group Name: _____

Insurance Company Address: _____

Employer: _____ Ins Co Phone#: _____

Secondary

Policy Holder Name: _____ Date of Birth: _____SS#: _____

Patient's relationship to the insured: ___Self ___Child __Other:_____ Insurance Company:_____

Subscriber ID#_____ Group#_____ Group Name: _____

Insurance Company Address: _____

Employer: _____ Ins Co Phone#: _____

FINANCIAL POLICY

Tree House Dentistry for Kids is committed to providing the best possible dental care to your child. Please understand that payment of your bill is considered a part of your treatment, and it is due at the time services are rendered. If you have dental insurance, we are happy to submit claims, on your behalf, to your insurance carrier. Please understand that this is not a guarantee of payment, from the insurance company. Your full co-payment is due at the time of treatment, and you will be billed, in full, for any services, upon receipt of the statement. We will gladly accept Cash, Debit and Credit cards. Tree House Dentistry for Kids reserves the right to turn any patient over to a collection agency, if it is deemed that the account has been in default of payment obligations or compliance to this financial policy. You will be responsible for all collections-related fees.

APPOINTMENT POLICY

All patients are seen on an appointment-basis. In most cases, the procedure you are scheduled for requires that a definite amount of time be set aside to provide the best possible care for your child. Every effort will be made to minimize waiting. Our office will make every effort to confirm your appointment. If you must reschedule your appointment, please contact our office as soon as possible. At least a 24-hour notice will be greatly appreciated. Giving us this courtesy allows us to schedule another child, in need of dental care. Our office has a "three-strike" policy for "No Shows." Each "No Show" will count as a strike. After three strikes, you will be dismissed from our practice. *We appreciate your understanding and acknowledgment of our office policies!*
I have read, understand, and agree to the terms of the above Financial and Appointment Policy of Tree House Dentistry for Kids.

Signature of Legal Parent or Guardian Date

Print Name Relationship to patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your privacy and rights are very important to us. Therefore, our notice of privacy practices is made available to you, **in our reception area**, as required by federal law. By signing this section, you acknowledge that you have been given Tree House Dentistry for Kids' Notice of Privacy Practices. This notice provides information about how we may use and disclose your protected health information to carry out treatment, payment activities, and healthcare operations. We strongly encourage you to review the notice carefully.

I acknowledge receipt of Tree House Dentistry for Kids' Notice of Privacy Practices. I have read and understand this authorization. I have asked questions about anything that was not clear to me, and I am satisfied with the answers I have received. I also understand that I have the right to revoke this permission.

Signature of Legal Parent or Guardian Date

Print Name Relationship to patient

CONSENT FOR DENTAL TREATMENT

Please read this form carefully. If there is any part you do not understand, please ask us for clarification.

I, the undersigned, have had the treatment plan for my **child or legal ward** explained to me. The nature and purpose of the procedures have been explained to me in general terms, which I understand. Alternative procedures, if any have also been explained to me, along with their advantages, disadvantages, and risks. I realize that good results are expected, but the possibility and nature of complications cannot be accurately anticipated; therefore, no guarantees, expressed or implied, can be given for treatment results.

I give my permission for the dentist and/or any auxiliaries supervised by the dentist to perform the following procedure(s) on my child or legal ward, as deemed necessary, by the dentist. In general terms, the dental treatment or procedure *may* include, but are not limited to the following:

1. Comprehensive oral examination, Radiographs, cleaning of teeth, and the application of Fluoride.
2. **Photo Release:** I give my permission to use my or my minor child's likeness in photography for publication, promotional purposes, website, media press releases and coverage, and any other such purpose on behalf of Tree House Dentistry for Kids. I understand that I, or my minor child, will not receive compensation for the use of this likeness in any form. The doctor or staff has specifically discussed the use of my child's photo on the social media sites of Tree House Dentistry for Kids, and I hereby consent to the usage of my child's photo and first name only. I understand that these are public sites.
   If you do NOT consent to the photo release of your child(ren) or legal ward, please initial here: _____
3. Other: _____

The risks involved with the above-mentioned procedures, alternatives to those procedures and the risks therein involved, and the risk of no treatment have also been explained to me; and I understand the explanations. I have been given an opportunity to ask questions about the treatment(s). I understand that I have the right to be provided with answers to questions that I might have during the course of my child's treatment.

I have read and understand this consent form. All questions have been answered in a satisfactory manner, and I have sufficient information to provide this informed consent. I understand that this consent shall remain in effect until terminated by me, and that I am free to withdraw my consent to treatment at any time.

Signature of Parent or Guardian Signature of Witness

Relationship to Patient Date

A legal guardian, who wishes to have their child be accompanied by a person, other than themselves, must complete the section below.

Power of Attorney

I, the undersigned, hereby authorize _____ to bring in _____ to receive dental treatment.

I give permission to Tree House Dentistry for Kids to administer any necessary treatment in the event of a medical emergency.

Signature of Parent or Legal Guardian: _____ Date _____

If the patient is a ward of the State of Washington, please complete the section below.

Case Worker Information

Name of caseworker: _____ Office Name: _____

Phone Number: _____ Fax Number: _____

Is the caseworker the legal guardian? YES NO If NO, who is the patient's legal guardian? _____

Responsible Party Information

The following is for: ___the patient's parent(s) or legal guardian ___the person responsible for payment

Name: _____ Date of Birth: _____ Relationship to patient: _____

Address (if different from the patient's): _____