

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Birth Date: _____

Please describe some of your goals you have for your child during the following appointments:

Initial Appointment - _____

Future Appointments - _____

Health Information

Date of Last Dental Exam:: _____

Has your child ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- Has your child ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Is your child now under the care of a physician? Yes No **Taking medications daily?** Yes No
Name & dosage: _____
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Does your child have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If my child ever has a change in health, I will inform the Puyallup Pediatric Dentistry at the next appointment without fail.

Signature of patient, parent or guardian _____

Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Stuart G. Hersey, DDS, MSD
8012 – 112th St. Ct. E. Suite 220
Puyallup, WA 98373
253-864-9889

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I may request a copy of the Notice of Privacy Practices for the offices of Stuart G. Hersey, DDS, MSD. The notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that might occur in his/her treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Stuart G. Hersey, DDS, MSD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I here specifically authorize disclosure of my child's protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY YES NO
SPOUSE ONLY YES NO
OTHER (*please specify*) YES NO

Name of Patient(s)

Name of Parent/Guardian

Signature of Parent/Guardian

Relationship to Patient

Date

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Provided prior to treatment? YES NO Date provided _____

REASON FOR DENIAL:

- § Needed more time to review notice of Privacy Practices
- § Wanted to consult with another person, before signing.
- § Unable to sign
- § Reason not given.
- § Other (*explain*)

New Patient Information Form

Name of Child _____			
<small>Last Name</small>	<small>First Name</small>	<small>Initial</small>	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Birth date _____	Nickname _____
			Hobbies _____
Home Address _____			
<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>
Mailing Address _____			
<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>
Person financially responsible _____			Home Phone _____
Who may we thank for referring you? _____			

Father's/Guardian's Name _____
Address if different from patient('s) _____
Home Phone _____ Work Phone _____
<small>(If different from above)</small>
Employer _____
Soc. Sec. # _____
Date of birth _____
Do you have dental insurance coverage for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____
Phone # _____
Address _____
Group # _____

Mother's/Guardian's Name _____
Address if different from patient('s) _____
Home Phone _____ Work Phone _____
<small>(If different from above)</small>
Employer _____
Soc. Sec. # _____
Date of birth _____
Do you have dental insurance coverage for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____
Phone # _____
Address _____
Group # _____

In the event of an emergency, whom should we contact? (other than parents)		
Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

The information that I have given is correct to the best of my knowledge. I understand 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 for my minor/child.

Signature of Parent / Guardian

Date

I certify that my child is covered by insurance and I assign directly to Dr. Stuart Hersey all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Stuart Hersey to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic

Signature of Parent / Guardian

Date

Puyallup Pediatric Dentistry

Appointments:

In order to provide all our patients with optimum care, we reserve specific times for their appointments. We respectfully request that you contact us two working days prior to that time in the event that an appointment needs to be rescheduled. This allows us to accommodate other patients with urgent dental needs.

All appointments are reserved specifically for your child. If you arrive late, we may need to reschedule your child's appointment if it inconveniences the patients to be seen after your child. Please allow plenty of time to arrive a few minutes earlier than scheduled. We strive to seat all of our patients on time.

We do not bill our patients for failed appointments, we simply ask for mutual respect of our time. However, when a treatment appointment is failed or cancelled without adequate notice, we may require a \$100.00 deposit to reschedule the appointment. The deposit will be applied to your co-payment when treatment is complete, but it will not be refunded if the appointment is missed. After two cancelled or failed appointments, without adequate notification, we will ask that you find a provider who is better able to accommodate your needs. Failed initial exam appointments will not be rescheduled.

Records:

As a courtesy to you, records will be duplicated at no charge for the first time. We require two working days notice to have your duplicated records ready for you to pick up or send. If records need to be duplicated more than once, an administrative fee of \$20.00 may need to be paid prior to the records being released.

Financial:

- Accounting reduction for treatment paid in full.
 - 7% Accounting reduction for treatment paid in full by cash or check.
 - 4% Accounting reduction for treatment paid in full by credit card.
- For those with no benefit coverage, pay by appointment. This option allows you to divide your financial responsibility by the number of appointments needed to complete your child's treatment.
- Insurance on Assignment. We will do our very best to estimate your out of pocket investment based on information received by your benefit plan. Understand this is only an estimate and not a guarantee of benefits.
- VISA/MC Easy Pay method. With your written permission, we will automatically deduct your set payment from your VISA or MasterCard.
- Healthcare Financing. We work with financial partners to offer our patients the option of an extended payment plan. This option allows you to make smaller payments over a longer period of time.
- Personal checks are gladly accepted however if a check is returned a \$35 charge will be applied and personal checks will no longer be accepted as a method of payment.

As a courtesy to you, we will assist you in maximizing your benefits and providing your insurance company with everything they need to process your claim in a timely manner. Your insurance is a contract between your employer and the insurance company. Your benefit is based on how much coverage your employer purchased for you. If we have not received payment within 60 days from the time of service, you may be responsible for paying the balance on your account, and you can look to your insurance company for reimbursement.

At your child's exam appointment, Dr. Hersey will present treatment recommendations based on the best treatment for your child. We will estimate your investment and if you have insurance coverage that we bill, we will estimate your co-payment. **All personal payments are due in full at each appointment.** If payment is not received, a one time billing fee of \$12.00 per each \$100.00 balance may apply. Should it be necessary to send more than one statement for any personal amounts owed, we will require all future appointments to be paid in full at the time of service. *You may look to your insurance carrier for direct reimbursement to you for any amount covered by your insurance.*

In the cases where a parenting plan exists, the parent that brings the child in for the appointments is considered the guarantor and is responsible for payment. They may then seek reimbursement from the other parent. If you are unable to make a co-payment at the time of service, please contact our office. We will make every attempt to work with you. We do partner with an outside lender to allow our patients to make smaller payments over an extended period of time (\$700 minimum).

These financial options meet the needs of most families in our practice. We want to be flexible in changing times. We have listened to your concerns and have made great efforts to respond to those concerns. We will do our very best to work out a financial solution to meet your personal situation. Let us know how we can help you.

I have read and understand all of the above guidelines. Please feel free to ask for a copy at your next appointment.

Acceptance:

Parent/Guardian Name

Date