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:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism _____
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

- 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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend or relative ☐ Dental Office
☐ Internet search ☐ Facebook ☐ School ☐ Work ☐ Other _____

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

Stuart G. Hersey, DDS, MSD
11201 88th Ave E. Suite 120
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 (Spouse, Children, Children's Spouses)	☐ YES	☐ NO
ANY MEMBER OF MY EXTENDED FAMILY: (Parents, Grandchildren)	☐ 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 _____

Last Name First Name Middle Initial

Sex ❑ **M** ❑ **F** **Age**_____ **Birth date**_____ **Nickname**_____**Hobbies**_____

Mailing or Home Address_____

Street City State Zip

Home Phone_____**Cell Phone**_____ **Email:** _____

Best number to reach you? ❑ **Home** ❑ **Cell** ❑ **Email** **Who may we thank for referring you?**_____

Father's/Guardian's Name_____

Address if different from patient('s)_____

_____

Home Phone_____ **Work Phone**_____

(If different from above)

Employer_____

Soc. Sec. #_____

Date of birth_____

Do you have dental insurance coverage for your child? ❑ **Yes** ❑ **No**

Plan Name_____

Phone #_____

Address_____

_____

Group #_____

Mother's/Guardian's Name_____

Address if different from patient('s)_____

_____

Home Phone_____ **Work Phone**_____

(If different from above)

Employer _____

Soc. Sec. #_____

Date of birth_____

Do you have dental insurance coverage for your child? ❑ **Yes** ❑ **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
Office Policies

Please review our office policies which we consider guidelines for the practice. We do understand at times there are extenuating circumstances, we will evaluate and accommodate unique situations on a case-by-case basis.

Scheduling and Cancelation

We ask all parents and guardians to reserve appointment times in advance. As a courtesy we will call to confirm the appointment two business days prior. We ask for the same consideration (two business days) when canceling or rescheduling an appointment.
There is a $50 charge for missed appointments or late cancelations *per* patient. Should these occur frequently, we may suggest alternate scheduling options or recommend another provider with a schedule that can accommodate your family's needs.

Record Requests

Please allow 10 business days to process any records request of our office.

Financial

All estimated patient portions are due at the time of service. We extend a 5% cash discount for payments made with cash or check.
Visa, MasterCard, and Discover are accepted; due to fees we incur upon processing we are not able to extend the 5% discount to these forms or payments.
Care Credit is an alternate form of credit that we will accept in office. Please ask for details if alternate payment options are needed. 5% discount does not apply.
Payments to be made with an HSA account? Please let us know upon check-out for assistance with their policies and limitations.

Billing

Insurance is billed as a courtesy and we estimate the patient portion from information obtained. When insurance pays less than expected, we will bill any residual monies owing. Residual balances are expected upon receipt. No insurance? We ask for all charges to be paid in full at the time of service.
12% finance fee will be assessed for balances over 60 days and will continue to accrue until account is paid in full.
A $35 fee will be assessed for all checks returned due to non-sufficient funds.

By signing below I understand, acknowledge, accept, and intend to follow these guidelines. If for any reason that I cannot comply, I will notify the office right away.

Signature:_____ Date: _____

Printed Name:_____