CHILDREN'S DENTAL CARE

Kent Office ▪ 24837 104th Ave SE Suite 200 ▪ 253-850-1234
Bonney Lake Office ▪ 18008 State Route 410 E. Suite B ▪ 253-826-5000

CHILD'S NAME					( )
	LAST NAME	FIRST NAME	MIDDLE INITIAL		NICKNAME
ADDRESS	STREET	APT. NO.	CITY	STATE	ZIP
AGE	DATE OF BIRTH	SEX	HOME PHONE NUMBER		CELL PHONE NUMBER

GUARDIAN INFORMATION		GUARDIAN INFORMATION	
NAME:	(RELATIONSHIP TO PATIENT)	NAME:	(RELATIONSHIP TO PATIENT)
BIRTHDATE:	SS*:	BIRTHDATE:	SS*:
DRIVER'S LIC. #		DRIVER'S LIC. #	
HOME PHONE:	CELL #	HOME PHONE:	CELL #
HOME ADDRESS:		HOME ADDRESS:	
WORK PHONE:	E-MAIL:	WORK PHONE:	E-MAIL:
EMPLOYER'S NAME:		EMPLOYER'S NAME:	

INSURANCE INFORMATION (BE SURE THAT ALL INFORMATION IS LISTED)

INSURANCE COMPANY NAME & ADDRESS	POLICY HOLDER(SUBSCRIBER)	POLICY NUMBER/GROUP NUMBER
1)_____	_____	_____
2)_____	_____	_____

RELATIVE WHOM WE CAN CONTACT IN THE EVENT OF AN EMERGENCY (NOT LIVING AT SAME HOUSEHOLD)

NAME _____ PHONE _____
(LAST) (FIRST) (MIDDLE)

ADDRESS_____
(NUMBER & STREET) (CITY) (STATE) (ZIP)

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____ SOC. SEC. # _____

TO KEEP THE COST OF DENTISTRY DOWN, WE ACCEPT ONLY PAYMENT IN FULL THE DAY OF TREATMENT FOR AMOUNTS NOT COVERED BY INSURANCE. PLEASE CHECK ONE OR MORE OF THE FOLLOWING CONVENIENT OPTIONS:

CASH VISA MASTERCARD DEBIT CARD

ACCT # _____ EXP. DATE _____

I HEREBY AUTHORIZE THE OFFICE OF CHILDREN'S DENTAL CARE TO PROCESS PAYMENT FROM TIME TO TIME AS THE OFFICE SEES FIT TO PAY MY ACCOUNT IN FULL.

SIGNATURE _____ DATE _____

THE PARENT THAT COMPLETES THE HEALTH FORMS AND ACCOMPANIES THE PATIENT TO ALL DENTAL APPOINTMENTS IS CONSIDED FINANCIALLY RESPONSIBLE FOR THE ACCOUNT.

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____ ADDRESS _____

WHO DOES THIS CHILD RESIDE WITH? _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF _____ (PATIENT NAME) AND GRANT CONSENT FOR BRAD HWANG, D.D.S. & ASSOCIATES TO TREAT _____ (PATIENT NAME). I AUTHORIZE ROUTINE DENTAL PROCEDURES FOR MY CHILD. IF I ACCEPT THE PROPOSED TREATMENT PLAN I ALSO AGREE TO THE USE OF ANESTHETICS AND PREMEDICATIONS CONSIDERED NECESSARY OR ADVISABLE BY THE DENTIST FOR THE COMFORT AND WELL BEING OF THE CHILD.

I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT. CHARGES SHOWN BY STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS PROTESTED IN WRITING WITHIN THIRTY DAYS OF BILLING DATE. IN THE EVENT IT SHOULD BECOME NECESSARY TO PLACE FOR COLLECTION ANY UNPAID BALANCE DUE FOR SERVICES RENDERED TO ME OR MY FAMILY. I/WE AGREE TO PAY COLLECTION FEES, AND SHOULD LEGAL ACTION BE FILED, REASONABLE ATTORNEY FEES, FILING FEES AND ANY OTHER COSTS THE COURT DETERMINES PROPER.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD BECAUSE OF ANY INSURANCE COVERAGE OR THE PENDENCY OF CLAIMS THEREON, AND ALL PROCEEDS OF INSURANCE ASSIGNED TO THIS OFFICE WHERE APPLICABLE, BUT WITHOUT THEIR ASSUMING RESPONSIBILITY FOR THE COLLECTION THEREOF. (A COPY OF THIS AGREEMENT IS AS VALID AS THE ORIGINAL AS WELL AS ANY ELECTRONIC OR SCANNED COPIES)

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ AND AGREE TO THE CONDITIONS SET FORTH. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT AT THE TIME YOU SIGN. READ IT TO PROTECT YOUR LEGAL RIGHTS.

SIGNATURE _____ DATE _____

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MEDICAL HISTORY AND INFORMATION

CHILD'S PHYSICIAN: _____ DATE OF LAST MEDICAL EXAM: _____

PHYSICIAN'S PHONE NUMBER: _____

1. IS YOUR CHILD:

   IN GOOD HEALTH? ☐ YES ☐ NO UNDER A PHYSICIAN'S CARE? ☐ YES ☐ NO

   TAKING MEDICINE(S)? ☐ YES ☐ NO

   MEDICINE(S): _____

   DOSE(S): _____

2. HAS YOUR CHILD HAD ANY HISTORY OF ILLNESS OR DIFFICULTY WITH THE FOLLOWING? (CIRCLE ALL THAT APPLY)

ANEMIA	ASTHMA	AUTISM	BEHAVIOR PROBLEMS	CANCER
CEREBRAL PALSY	TUMOR	DIABETES	DRUG REACTION	ENDOCRINE
HEARING IMPAIRMENT	HIV + OR AIDS	LIVER	HYDROCEPHALUS	HEADACHES
LEARNING DISABILITY	HEPATITIS	KIDNEY	SPEECH DISORDER	VISION IMPAIRMENT
DEVELOPMENTAL DELAY	SEIZURES	THYROID	BLEEDING DISORDER	HEART DEFECT, DISEASE, OR MURMUR

3. DOES YOUR CHILD HAVE ANY ALLERGIES? (DRUG, FOOD, **LATEX**, POLLEN) SPECIFY: _____
4. HAS THE CHILD BEEN HOSPITALIZED OR REQUIRED SURGERY? IF YES, DESCRIBE YES NO

   DATE(S): _____

   CONDITION(S): _____
5. WHICH BEST DESCRIBES YOUR CHILDS PERSONALITY? (CIRCLE ONE) NORMAL SHY NERVOUS DIFFICULT

DENTAL HISTORY

PREVIOUS OR REFERRING DENTIST: _____ DATE OF LAST DENTAL VISIT: _____

DENTIST'S ADDRESS: _____

WHAT IS THE MAIN CONCERN OF YOUR CHILD'S DENTAL HEALTH: _____

1. HAS YOUR CHILD COMPLAINED ABOUT DENTAL PROBLEMS? YES NO
2. ANY UNHAPPY DENTAL EXPERIENCES? YES NO
3. ANY INJURIES TO MOUTH, TEETH, OR HEAD? *IF YES, DESCRIBE*: YES NO

   _____
4. ANY MOUTH HABITS? (CIRCLE ALL THAT APPLY) NURSING BOTTLE THUMB SUCKING PACIFIER MOUTH BREATHING NAIL BITING
5. ARE THE TEETH BRUSHED? OCCASIONALLY ONCE DAILY MORE OFTEN
6. ARE THE TEETH FLOSSED? OCCASIONALLY ONCE DAILY MORE OFTEN
7. DOES PARENT ASSIST THE CHILD WITH BRUSHING? YES NO
8. DOES PARENT ASSIST THE CHILD WITH FLOSSING? YES NO
9. IS FLUORIDE TAKEN IN ANY FORM (OTHER THAN TOOTHPASTE)? YES NO
10. ANY DIFFICULTY WITH THE JAW JOINTS, "TMJ"? (CIRCLE ONE) NONE CLICKING POPPING PAINFUL OPENING DIFFICULTY

PARENT COMMENT: (IS THERE ANYTHING ELSE ABOUT YOUR CHILD YOU THINK WE SHOULD KNOW?)

_____

CHILD'S NAME _____ RELATIONSHIP TO PATIENT: _____

YOUR SIGNATURE: _____ DATE: _____ REVIEWED BY: _____