

thank you for selecting us.

Patient ID # _____

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____

Nickname _____ SS#/SIN _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____ Phone _____

Responsible Party

Name _____ Relationship _____

Address _____ Email _____

City _____ State/Prov. _____ Zip/P.C. _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS#/SIN _____ DL # _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information **Mother** **Stepmother** **Guardian**

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information **Father** **Stepfather** **Guardian**

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status Single Married Separated Divorced Widowed

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

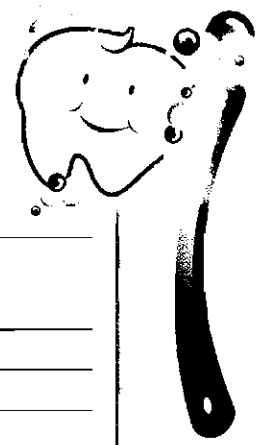
Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please



Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.) Yes No

Grind Teeth Yes No

Clench Jaws Yes No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? Yes No

Has your child ever taken Fen-Phen/Redux? Yes No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____ When? _____

Is your child currently taking any medications? Yes No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor) _____ Date _____

Dentist's Review:

Signature of Dentist _____ Date _____



Acknowledgment of Privacy Practices & Patient Consent Form

Costa & Dageenakis Family Dentistry
 1565 Woodridge Dr SE, Port Orchard, WA 98366
 (360) 876-0550

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996(HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations, and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relation to Patient: _____ Date: _____

Signature _____
 Dependent family members also covered by this acknowledgement: _____

Authorization to Release Information to Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

- You May Disclose My Information To The Following
 Do Not Disclose My Information to Anyone But Me

Name _____ Relation to Patient: _____ Date: _____

Name _____ Relation to Patient: _____ Date: _____

Name _____ Relation to Patient: _____ Date: _____

For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

The patient refused to sign _____ Communication Barriers _____ Emergency Situation _____ Other _____

Marta R. Costa, D.D.S.
 Miranda S. Dageenakis, D.D.S.

OFFICE FINANCIAL POLICIES

The following financial policies have been prepared to better prepare you for your dental treatment and to help eliminate any confusion regarding necessary payments. Please read thoroughly and feel free to ask any questions.

1. An estimate of fees for any treatment is available upon request.
2. You are fully responsible for all charges. If you have insurance, we will submit it for you as a courtesy. In many cases we can estimate closely what your patient portion will be and payment of that amount is expected at the time of service.
UNFORTUNATELY, WE CANNOT GUARANTEE ANYTHING YOUR INSURANCE COMPANY SAYS REGARDING ELIGIBILITY OR BENEFITS, BUT WILL TRY TO HELP IN CASE YOU HAVE A DISPUTE WITH THEM. WE ARE NOT RESPONSIBLE FOR INSURANCE NON-PAYMENT OR UNDERPAYMENT FOR ANY REASON. YOU REMAIN PRIMARILY RESPONSIBLE FOR PAYMENT.
3. Payment is expected at the time of service.
IF YOU HAVE INSURANCE, WE REQUEST THAT YOU PAY YOUR ESTIMATED PORTION AT THE TIME SERVICES ARE RENDERED.
4. At least half of the fee for dental treatment that is considered major, (crowns, bridges, dentures, partial dentures & root canals) must be paid when the procedure is begun and the final payment made at the insertion appointment.
5. We accept cash, checks, Visa and MasterCard.
6. Any outstanding balances exceeding 60 days receive a 1% per month service charge. Outstanding balances exceeding 90 days will be charged a \$15.00 late fee per month there after.
7. NSF checks will result in a \$40.00 Charge.
8. Please ask whenever you have any questions regarding your treatment charges. We will be glad to answer any of your questions.
9. **We reserve the right to charge a missed/cancelled appointment fee of \$40.00 per hour for appointments with less than 24 hours notice.**

I HAVE READ AND ACCEPT THE FINANCIAL POLICIES AS EXPLAINED ABOVE.

Patient (Print)

Patient
Parent or Guardian if Minor
(Signature)

Date