Last Name	First Name	Middle	Date of Birth	Age

Dental History

1. Is this your child's first visit to a dentist? □ Yes □ No Previous Dentist _____
2. Please describe your child's problem or reason for visit: ____
3. Please check if your child has (or had):

	Y	N		Y	N		Y	N		Y	N
Tooth ache			Trauma to the Face			Finger Habit			Bad Breath		
Facial Swelling			"Cold Sores" or any ulcers in the mouth			He/She "grinds" his/her teeth			Fluoride "drops"		
Gumboil or any dental abscess			Dental Treatment under Oral Sedation			Dental Treatment under General Anesthesia			Bleeding from the "gums" (gingivitis)		

4. Do you supervise your child's tooth brushing? □ Yes □ No. Toothpaste brand:_____
5. Do you floss your child's teeth? □ Yes □ He/she does it on his/her own □ No.
6. Does he/she use any type of Fluoride rinses? □ Yes □ Yes, but just mouthwash □ No.

Medical History

1. Who is your child's pediatrician or family doctor? _____
   Date of last Visit:____/_____/_____ Reason: _____
2. Is your child under "any" treatment by his/her physician? □ yes □ no. Please describe: _____
   _____
3. Please list all medications and dosages your child is currently taking: _____
   _____
4. Has your child ever been hospitalized? □ yes □ no. Why? _____
   _____
5. Has your child had a serious health event in the last month? □ yes □ no. Please describe: _____
   _____
6. Please describe your child's overall physical health: □ Excellent □ Good □ Fair □ Poor
7. Was your child born full-term? □ yes □ no. If "no", please elaborate: _____
8. Please check the box if your child has (or had in the past) any of the following:

	Y	N		Y	N		Y	N		Y	N
Heart Disease			Urinary Infection			Food Allergy			Speech difficulty		
Heart Murmur			Kidney Disease			Allergies			ADD/ ADHD		
Heart surgery			Muscle Disease (cerebral palsy, other)			Liver Disease or Hepatitis			Psychiatric Problems		
Bleeding disorders/ Anemia			Epilepsy, Seizures or treatment for seizures			Heartburn or Peptic Ulcer			2nd Hand Smoking exposure		
Blood Transfusions			Asthma (mild, moderate or severe)			Sinus problems or Migraines			Developmental or Motor Delay		
Cancer			Diabetes			Sleep Apnea			Genetic Condition		
Chemotherapy			Thyroid Disease			Snoring			Fainting episodes		
Radiation			Allergy to Medicines			Weight Problems			HIV/AIDS		

Please Elaborate _____
_____

I certify that I am the duly authorized agent of the patient and that I have read and I understand the above questions. I will not hold Dr. Carlos Dorantes, his Associates, or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form

Signature: _____ Date: _____
Relationship to child:_____

TELL US ABOUT YOUR CHILD

Today's Date _____

First Name _____

Last Name _____

Date of Birth _____

Gender □ Male □ Female

Home Address _____

City:_____ Zip: _____

Emergency contact _____

Phone (____)_____ (____)_____

Relationship to Patient _____

Previous Dentist _____

Last visit _____

Whom may we thank for referring you?

_____

TELL US ABOUT YOU

Parents Name _____

Parents Address_____

City:_____ Zip:_____

Home Phone (____)_____

Work Phone (____)_____

Cell Phone (____)_____

□ **SPD can text me to remind me about appointments**

Alternate Contact _____

Alternate Phone (____)_____

Which phone is the best day time contact?

_____

INFORMATION FOR BILLING

Responsible Party _____

Relationship to child _____

Address (if different) _____

_____Zip _____

Employer : _____

SSN # _____ DOB: ____ /_____/____

Email: _____

□ SPD can email me to remind me about appointments.
□ SPD can take photos of my child for their "Cavity Free Club" and/or for clinical purposes.

□ My Child has Medical Coupon/DSHS/Provider ONE (check here)
□ My Child has private dental insurance (check here)
□ My Child has no dental insurance (check here)

PLEASE FILL INFORMATION BELOW

□ Medical Coupon/DSHS/Provide ONE (check here)

PRIMARY DENTAL INSURANCE

Ins. Co. Name _____
Co. Phone _____
Group # _____Plan #_____
Insured's Name _____
Relationship to Patient _____
Insured's DOB _____ SSN_____
Insured's Employer _____

SECONDARY DENTAL INSURANCE

Ins. Co. Name _____
Co. Address _____
_____
Co. Phone _____
Group # _____Plan #_____
Insured's Name _____
Relationship to Patient _____
Insured's DOB _____ SSN_____
Insured's Employer _____

The undersigned hereby authorizes payment to Carlos Dorantes DDS, PLLC (Summitview Pediatric Dentistry) of insurance benefits otherwise payable to me. I also authorize Dr. Dorantes to perform examination and treatments, including the administration of medicine, local anesthetics, and extractions along with other surgical and dental procedures that may be deemed necessary for the care of the above mentioned child. I certify that the information on this page is true and correct to the best of my knowledge. This consent shall remain in full force and effect until cancelled by either party.

Signature _____ Date _____

□ Parent □ Guardian

Office Policies

Dr. Dorantes and his staff would like to thank you for allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications of our office policies.

Parent Information

We ENCOURAGE you to stay with your child during the initial examination as this will give you an opportunity to meet our staff and will allow the doctor to discuss ALL dental findings and treatment directly with you. During future appointments, we encourage your child to accompany our staff through the dental experience by him/herself; however unlike other clinics, our office has a very open **PARENT IN POLICY** so you are welcome inside the treatment area at any point. If you are coming to our office with other children that do not have an appointment for that time, please make sure that they wait IN THE GAME AREA.

Appointment Policy

If you cannot keep an appointment, please give us at least **48 HOURS NOTICE**. Any No-Show, missed appointment or cancellation (with less than adequate notice) will carry a $50 fee payable on next visit. If there is **ONE BROKEN APPOINTMENT** within your family we have the right to dismiss you from our practice. We make great efforts in contacting you to confirm your appointment, however if we fail to reach you, the appointment will be cancelled and it will be considered as a BROKEN appointment.

Insurance Policy

We accept most major dental insurance plans including WA Medicaid. Your insurance company is a third party in payment participation of your child's dental treatment. While it may help pay part of the cost of your child's care, it may not cover the entire amount of the services provided. Please understand that we can only provide you with just an estimate of your insurance benefits. Our estimate of your insurance benefits is only our "best guess" regarding the extent to which your insurance might be expected to pay. In order for you to receive the maximum benefits available from your insurance, you will need to provide us with as accurate dental information as possible.

We are a fee-for-service office, so we ask that any amount not covered by insurance be paid at the time of service. Patients are fully responsible for payment of all treatment, regardless of insurance coverage.

I have read and understand the Office Policies and agree to abide by its contents:

Parent/Legal Guardian :_____ Date: _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Carlos Dorantes. The statement of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or the performance of office health care operations. The statement of privacy practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The statement of privacy practices is also posted in the facility.
Summitview Pediatric Dentistry reserves the right to change the privacy practices that are describe in the statement of privacy practices. If privacy practices change, I will be offered a copy of the revised statement of privacy practices at the time of my first visit after the revision s become effective. I may also obtain a revised statement of privacy practices by requesting that on be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures describe in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the person/persons indicated below:

ANY member of my immediate family	□ YES □ NO	Initials _____
Spouse Only	□ YES □ NO	Initials _____
Other (please specify):_____	□ YES □ NO	Initials _____

_____ _____

Name of Patient *Signature of Patient or Personal Representative*

_____ _____

Date *Relationship to Patient*

For office use only

I attempted to obtain the Patient's or Patient Representative's signature in acknowledgement on this Statement of Privacy Practices, but was unable to do so as documented below:

Date:	*Initials:*	*Reason:*