

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

• 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 _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> Last Name First Name Middle Initial </div>		
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birth date _____ Nickname _____ Hobbies _____		
Mailing or Home Address _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> Street City State Zip </div>		
Home Phone _____ Cell Phone _____ Email: _____		
Best number to reach you? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Email Who may we thank for referring you? _____		
Father's/Guardian's Name _____ Address if different from patient('s) _____ <hr/> 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 _____ <hr/> Group # _____	Mother's/Guardian's Name _____ Address if different from patient('s) _____ <hr/> 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 _____ <hr/> 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
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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
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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 Cancellation

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 cancellations *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: _____