3205 SE 192nd Ave Suite 100, Vancouver WA 98683
Office 360-891-9283 Fax 360-891-9283
www.undertheseakidsdentist.com

Child Health and Dental History Form

Child's Name:_____ DOB_____

Address:_____

Phone#_____ Gender: Male Female

1st Parent Information

Mother Father Guardian Foster Stepparent

Name:_____ DOB_____

Phone#_____ Secondary Phone#_____

Email:_____

Email/Text Appointment Confirmations? YES NO

2nd Parent Information

Mother Father Guardian Foster Stepparent

Name:_____ DOB_____

Phone#_____ Secondary Phone#_____

Email:_____

Email/Text Appointment Confirmations? YES NO

How did you hear about us? Please write name below

Family Friend_____ Doctor_____

Advertisement_____Other_____

Pediatrician Name:_____ Phone#_____

Specialist Name:_____ Phone#_____

Health History

Please Check if you child has had a history of, or currently has any condition related to any of the health conditions below:

o **Accidents or Severe Infections**	o **Ear aches/infections**	o **Speech Issues**
o **Allergies (Seasonal)**	o **Enlarged Tonsils**	o **Skin Issues**
o **Anemia or Blood Disorders**	o **Headaches**	o **STD**
o **Arthritis**	o **Heart Murmur**	o **Thyroid/Endocrine Issues**
o **Asthma or Lung Problems**	o **Hepatitis/Liver Disorders**	o **Tobacco/Drug use**
o **Autism or Autistic Spectrum**	o **HIV+/AIDS**	o **Tuberculosis**
o **Bladder or Kidney Problems**	o **ADHD/ADD**	o **Vision Disorders**
o **Bone Disorders**	o **Latex Allergy**	o **Other _____**
o **Bleeding Problems**	o **Measles**	_____
o **Blood Transfusion**	o **Mumps**	_____
o **Cancer (Malignancies)**	o **Pregnancy (Teen)**	_____
o **Cerebral Palsy**	o **Rheumatic Fever**	
o **Convulsions, Seizures or Epilepsy**	o **Sickle Cell**	
o **Developmental Disabilities**	o **Snoring**	
o **Diabetes**		

Please List any food allergies: _____
_____
_____

Please List any current medications:
_____
_____
_____

Does your child have any allergies to medications? YES NO If yes please list:
_____
_____
_____

Medical History

YES NO 1.) Has your child ever been hospitalized or had any type of surgery?
If yes, please explain: _____

YES NO 2.) Has your child ever had any type of sedation or general anesthesia?
If yes, please explain: _____
Any complications? _____

YES NO 3.) Does your child have any developmental, mental, or physical-
Impairment? If yes, Please explain _____
_____

YES NO 4.) Has you child had any excessive bleeding when cut or injured?

YES NO 5.) Does your child require antibiotics for dental treatment due to a heart condition, prosthetics, shunt, organ transplant, or other medical reason?
If yes, please explain: _____

YES NO 6.) Does your child have any genetic or inherited disorders?
If yes, please explain: _____

YES NO 7.) Is your child being treated for any other illnesses not mentioned on This form? If yes, please explain: _____

Dental History

YES NO 1.) Is this your child first dental visit? If not, when was the last time?
_____

YES NO 2.) Has your child ever had an unpleasant experience at a previous Dentist? If yes, Please explain_____

YES NO 3.) Has your child every injured their mouth, teeth, or head?
If yes, please explain_____

YES NO 4.) What type of water does you child drink most frequently?

o City
o Bottled
o Filtered
o Well

YES NO 5.) Does your child take fluoride supplements?
If yes, please explain_____

YES NO 6.) Does your child use fluorinated toothpaste?

YES NO 7.) Do you brush your child teeth? How many times per day?_____
When?_____

YES NO 8.) Do you supervise or assist your child with brushing?

YES NO 9.) Does your child snack frequently between meals?

YES NO 10.) How much juice does your child drink daily?

o None
o 4-6 oz (one cup)
o 6-12 oz (two cups)
o More than 12 oz

YES NO 11.) Does you child participate in any sports or other activities?
If yes, please explain_____

YES NO 12.) Has your child complained of any dental-related pain recently?
If yes, please explain_____

YES NO 13.) Do you have any other dental concerns or comments you wish Addressed? If yes, please explain_____

Habit History

Please let us know about past and current feeding and childhood habits

	Past	Current	Not Applicable	Age When Stopped
Breast Feeding				
Baby Bottle Use Contents:				
Sippy Cup Use Contents:				
Thumb/Finger Sucking				
Pacifier				
Teeth Grinding/Clenching				

Authorization:

I certify and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medial status.

_____

Printed Name

_____

Signature of Parent or Guardian

_____

Date

Dental Insurance Information

Primary:

Insurance Company Name: _____
Group#_____ ID/SSN#_____
Billing Address: _____Phone#_____
Policy Holders Name: _____
DOB_____ Relationship to Child: _____
Employer: _____

Secondary (if applicable):

Insurance Company Name: _____
Group#_____ ID/SSN#_____
Billing Address: _____Phone#_____
Policy Holders Name: _____
DOB_____ Relationship to Child: _____
Employer: _____

I certify that, as this child's parent/legal guardian, all of the information I have provided in this form has been completed to the best of my knowledge. I understand that my dental insurance carrier may pay less than the billable amount for services rendered. I agree to be responsible for all or any payment of all services rendered on behalf of my dependents.

Insurance fraud hurts you and your children, and can subject you to criminal and civil penalties. Due to the serious nature of this offense and because this conduct may increase the exposure and expenses incurred by this office, we must enforce this policy.

Please ensure you have notified our front desk of all private and state insurance plans your children is enrolled in. If insurance fraud is discovered after signing this form, Under the Sea Dentistry is entitled to:

- Administrative fee of $50.00
- Payment for any monetary difference between signed treatment plan and changes that result from new insurance information
- Refuse services and deactivate patients from the clinic
- Report of fraud to the proper authorities

Failure to disclose insurance information is a crime under Washington state law and is a class C Felony and can require jail time and fines.

I, _____ the legal guardian and or parent of the minor listed and have read and understand the insurance coverage form. Further, I have disclosed any and all forms of private and or state funded insurance available for my child(ren).

_____

Parent/Legal Guardian Signature Date

UNDER THE SEA
DENTISTRY FOR KIDS

I the parent/legal guardian is giving permission for those listed below to bring _____ my child/children to their appointments, make decisions for dental treatment and make future dental appointments. This is also authorizing, Under the Sea Dentistry for Children's staff to share any information they feel necessary to help aid in the treatment process for my child/children with those listed below.

Name: _____
Phone: _____
Relationship: _____

Name: _____
Phone: _____
Relationship: _____

Name: _____
Phone: _____
Relationship: _____

Parent Signature: _ **Date: _____**

3205 SE 192nd Ave Suit 100 Vancouver, Washington 98683
Office 360-891-9283 Fax 360-891-8030

UNDER THE SEA
DENTISTRY FOR KIDS

Office Policies

Patient:_____

At Under the Sea Dentistry, customer service is our top priority. It helps us to make sure that we are doing the very best for you and your family. In an effort to create an environment that allows us to be our very best, we have established office policies that we would like you to review. If you have any questions, please do not hesitate to ask us.

Late Arrivals: We ask that you arrive at least 15 minutes prior to your appointment time in order to answer any questions you may have, take care of any insurance or payment issues that may arise, and allow adequate time to care for your child. We always strive to minimize wait times for all patients. Therefore, in order to avoid compromising your child's care, and in fairness to other patients who have arrived on time, late patients may be reschedule if there is insufficient time to care for you child. We will try to accommodate late arrivals as time permits, but those patients who are on time will be seen first.

No Show Policy/Late Cancellations: We exclusively reserve time to care for your child, and we expect patients to be present at their appointment time. To avoid a charge of $25.00 for missed or late cancelled appointments, we request 48-hour notice. This fee must be paid before scheduling another appointment. We understand last minute issues may arise, and offer leniency in some cases, but repeatedly missed or cancelled appointments unfairly use time that may be offered to another child who requires dental treatment.

Photos/Videos: We understand that a child's first dental visit is an important milestone in your child's life. We ask that you inform us first, so that we may ensure that our staff does not appear in any recordings or pictures with out their consent. Also, we ask that you refrain from recording or taking pictures once procedures have started and during course of treatment.

Financing: We are committed to providing high-quality, affordable dental care for your child, we offer a variety of payment options.

Patients Without Dental Insurance: For patients without dental insurance, payment is due the same day services are rendered, regardless of who accompanies the child to his or her appointment. For your convenience, we offer a 10% discount for those who pay with cash, checks, and all major credit cards. We also offer low/no interest financing through Care Credit but due to the fees we are not able to offer a 10% discount.

In-Network Insurance Patients: We are preferred provider for many major insurance dental plans. If we are an in-network provider for you policy, we will file your claim as a courtesy and will accept estimates of benefit payments from these insurance companies. Your portion of co-payment and or/co-insurance is due at the time of service. Please keep in mind that this is only an estimate of what your insurance will cover for you. If there is any difference after your insurance pays, we will contact you to make the necessary proper adjustments.

Out-of Network Insurance Patients: If we are out of network for your insurance, please check for any out of network benefits and we will file your claim for you as a courtesy. Although we can sometimes estimate what your insurance company will pay, there is no guarantee of reimbursement. Any remaining balance will be your responsibility.

It is important to understand that ***your insurance is a contract between you, your employer, and the insurance company***, not our office. No matter what your insurance status may be, please keep in mind that, ultimately you are responsible for timely payment on your account. If your insurance company has not paid your claim in full within 30 days, you will be notified so that you can discuss the matter with your insurance company. If the claim is not paid within 45days, the balance and all follow-up with the insurance company becomes your responsibility and all remaining balances will be due with in 30 days.

Please call our office at (360) 891-9283 for more information, and let us know if you have any questions or concerns regarding our office policies. We value the trust that you have placed in us for your child's dental care. Welcome to the Under the Sea Dentistry Family.

I have read, understand and agree to abide by Under the Sea Dentistry office policies:

Print Name: _____

Signature: _____

Relationship to child: _____

Financial Agreement

Please Read Carefully

Patient Name:_____

___Initial If you do not have insurance to bill then payment is required same day the services are rendered.

__Initial Dental insurance is an agreement between you and your insurance company. We can only estimate your dental benefits. This estimate is not a guarantee of payment by your insurance company. You are responsible for any charges your insurance company does not pay.

___Initial Your Estimated out of pocket portion, (co-pays) and deductibles are due at time of service.

___Initial There is a $35.00 charge for any returned checks and then a check will no longer be accepted.

___Initial A billing charge will be applied to any account which has a balance 60 days past due. This monthly fee is a minimum of $10.00.

___Initial There is a $100.00 charge for all accounts that are sent to collections.

Printed Name:_____ Date_____

Signature_____

Relationship to child_____