19221 108th Avenue SE, Suite 4
Renton, WA 98055
tel (253) 852-4746 fax (253) 852-4754
info@drphilhodge.com
www.drphilhodge.com

Welcome

Thank you for selecting our dental healthcare team - we are pleased to welcome your child to our practice! To help us better serve the needs of your child and meet his/her dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us - we are happy to help!

Your Child

Child's Name ____________ Date ______
Wishes to be called ____________ Sex ❑ F ❑ M
Birthdate ____________ Age ______
Child's Home Address ____________
City ____________ State/Zip ______
Phone ____________
Whom may we thank for referring you?
____

Person Responsible for Scheduling?

Name ____________
Relationship to patient ____________

How can we best reach you?

❑ Cell ❑ Email ____________
❑ Pager ❑ Work ❑ Home

Time of Day ____________

Mother

❑ Stepmother ❑ Guardian

Name ____________
Home Phone ____________ Cell Phone ____________
Work Phone ____________ Ext. # ____________
Pager ____________ E-Mail ____________
Employer ____________ Occupation ____________
SS# ____________

Marital Status

❑ Single ❑ Married ❑ Other______

Father

❑ Stepfather ❑ Guardian

Name ____________
Home Phone ____________ Cell Phone ____________
Work Phone ____________ Ext. # ____________
Pager ____________ E-Mail ____________
Employer ____________ Occupation ____________
SS# ____________

Marital Status

❑ Single ❑ Married ❑ Other______

Responsible Party Other Than Listed

Name ____________
Relationship to patient ____________
Birthdate ____________ Soc. Sec. # ____________
Address ____________
City ____________ State/Zip ____________

Employer ____________ Occupation ____________
Work Phone ____________ Ext. # ____________
Home Phone ____________ Cell Phone ____________

Previous Dentist

Name ____________
City ____________

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Dental Insurance Information

Primary Insurance

Name of Insured ____________________
Relationship to Patient ____________________
Insured's Birthdate ____________________
Insurance ID. # ____________________
Employer ____________________
Occupation ____________________
Insurance Company ____________________
Group# ____________________
Ins. Co. Address ____________________
Ins. Co. Phone ____________________

Secondary Insurance

Name of Insured ____________________
Relationship to Patient ____________________
Insured's Birthdate ____________________
Insurance ID. # ____________________
Employer ____________________
Occupation ____________________
Insurance Company ____________________
Group# ____________________
Ins. Co. Address ____________________
Ins. Co. Phone ____________________

Authorization and Release

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____
Signature of parent/guardian Date

Thank you for filling out this form completely. The information you have provided will help us serve your child's dental healthcare needs more effectively and efficiently.

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DENTAL HISTORY

Is this your child's first dental visit? ❑ Yes ❑ No
Previous Dentist's Name? ______________________
Date of last visit: __________
Does your child feel nervous about having dental treatment? ❑ Yes ❑ No
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? ❑ Yes ❑ No
Has your child ever been premedicated for dental work? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets, or water? ❑ Yes ❑ No

HEALTH HISTORY

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized during the past 2 years? ❑ Yes ❑ No
Has your child been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name ______________________
Address ______________________ Phone: __________

Is your child currently taking any medications? ❑ Yes ❑ No
If yes, please list: ______________________
Has your child taken any medicine / drugs during the past 2 years? ❑ Yes ❑ No
If yes, please list: ______________________
Please list any serious medical condition(s) that your child has or has had: ______________________

____

Please check "Yes or No" to the following conditions:

Y N
❑❑ High / Low Blood Pressure
❑❑ Congenital Heart Defect
❑❑ Heart Murmur / Rheumatic Fever
❑❑ Heart Surgery
❑❑ Diabetes
❑❑ Blood Transfusion / Anemia
❑❑ Sickle Cell Disease
❑❑ Bruise Easily
❑❑ Hemophilia
❑❑ Frequent Headaches

Y N
❑❑ Liver Disease / Yellow Jaundice
❑❑ Kidney Failure/Disfunction
❑❑ Thyroid Disease
❑❑ Frequent Stomach Upset/Aches
❑❑ Chemotherapy / Cancer
❑❑ Asthma
❑❑ Cough / Tuberculosis (TB)
❑❑ A.I.D.S. / H.I.V.
❑❑ Hepatitis: A B C **(circle one)**
❑❑ Pain in Jaw Joint

Y N
❑❑ Fever Blisters / Cold Sores
❑❑ Fainting / Dizzy Spells
❑❑ Epilepsy / Seizures
❑❑ Hay Fever / Sinus Trouble
❑❑ Allergies / Hives
❑❑ Nervousness
❑❑ Psychiatric Treatment
❑❑ Drug / Alcohol Addiction

Other
____
____
____
____
____
____

Is your child allergic to or reacted adversely to any of the following?

❑ Antibiotics
❑ Codeine
❑ Metals/Jewelry
❑ Aspirin
❑ Latex
❑ Local/Dental Anesthetic

Does your child have allergies to any other medications or substances? If yes, please list:

____
____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Philip Hodge and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature ______________________ Date ____/____/____

Medical History Update
(For Office Use Only)

Date ______ Comments ______________________
Parent's Signature ______________________
Date ______ Comments ______________________
Parent's Signature ______________________
Date ______ Comments ______________________
Parent's Signature ______________________
Date ______ Comments ______________________
Parent's Signature ______________________

Date ______ Comments ______________________
Parent's Signature ______________________
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Parent's Signature ______________________
Date ______ Comments ______________________
Parent's Signature ______________________

Philip N. Hodge, DDS, PS

The Fine Art of Dentistry

- Patient Financial Policy -

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options. Please select one.

1. Cash, Check, Debit
2. Visa, MasterCard, Discover, American Express
3. Payment Plan

We will, as a courtesy, process your insurance benefits in our office. Specific questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12) per year will be charged on accounts 90 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

____

Signature (responsible party) Date

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Philip N. Hodge, DDS, PS
19221 108th Ave. SE Suite 4
Renton, WA 98055
253-852-4746

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 dental 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 dental 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 *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 or health care operations and I understand that your are not required to agree to my requested restrictions, but if you do agree then your are bound to abide by such restrictions.

Patient Name: ________________________________ Date: ____________________

Signature: ____

Relationship to Patient: ______________________________

Dependent family members also covered by this acknowledgement:

____

____

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