PINE LAKE DENTAL CARE
FINANCIAL POLICY

We appreciate the opportunity to serve you! It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Please read the following carefully and ask us any questions you might have.

INSURANCE

As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We can estimate and will assist you in determining your insurance benefits**. Any patient portion is due at the time of service.** If for any reason, the estimated amount is not paid by your insurance company, **please remember that you are fully responsible for all fees** charged by this office regardless of your insurance coverage.

We encourage you to review your insurance policy in detail so that you are aware of your plan's specific benefits and maximum coverage. It is your responsibility to know your insurance coverage and to notify us of any changes that may occur.

NON-INSURED AND EMERGENCY SERVICES

Payment in full is required at the time of service.

PAYMENT OPTIONS

We accept **Visa, MasterCard, checks, and cash** for the amount due. We also offer financing through **CareCredit**. To apply for a line of credit, please contact us for more information. Courtesies are available for patients who pay in full with cash.

TWO BUSINESS DAYS NOTICE IS REQUIRED FOR RESCHEDULING APPOINTMENTS

Dr. Robertson and Dr. Phan reserve your appointment time exclusively for you. Please be considerate.

This is an agreement between Christopher C. Robertson, DDS, PS, as creditor, and the Patient/Debtor named on this form. By signing this agreement, you consent to treatment by Christopher C. Robertson, DDS, PS and his staff and agree to pay for all services that are received. In addition, you authorize Christopher C. Robertson, DDS, PS to release any necessary information requested by your insurance carrier and authorize payment directly to Christopher C. Robertson, DDS, PS for any benefits available under your insurance plan.

Patient's Name: _____

Responsible Party (If patient is under 18 years-old): _____

Signature: _____ Date: _____

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com

PINE LAKE DENTAL CARE
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been informed of the *Notice of Privacy Practices* for Pine Lake Dental Care, the dental office of Dr. Christopher C. Robertson, DDS, PS and Dr. Kimchi L. Phan, DDS. I have been given the right to review and receive a copy of the *Notice of Privacy Practices*. The *Notice 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 in the performance of health care operations.**

We reserve the right to change 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 changes become effective. I may also obtain a *revised Notice of Privacy Practices* by requesting that one be mailed to me.

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. I also 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.

In addition to the allowable disclosures described in *the Notice of Privacy Practices*, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below, if necessary:

Any member of my immediate family	Yes	No
Spouse only	Yes	No
Others (please specify)	Yes	No

Name of Patient: _____

Signature of Patient (or Guardian): _____

Date: _____

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:

- Patient's refusal to sign
  ___ needed more time to review Notice of Privacy Practices
  ___ wanted to consult with another person before signing
  ___ unable to sign
- Communication barrier
- Emergency situation
- Other

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PINE LAKE DENTAL CARE
NOTICE OF PRIVACY PRACTICES

We understand that information about you and your health is very personal and our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to be sensitive about and to respect the confidentiality of your healthcare information is never compromised. We may amend our privacy policies and practices, but you will always be informed of any changes that might affect your rights.

Protecting your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPPA) and the state of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use our information for marketing purposes without your written consent.

We may use/disclose your health information to communicate reminders about your appointments including voicemail and answering machine messages, emails and postcards.

Patient Rights

You have the right to request copies of your health care information. All such requests must be in writing. We may charge you for your copies the amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Please let us know if you have any questions regarding your privacy rights and the protection of your personal health information.

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PINE LAKE DENTAL CARE
CHILD REGISTRATION & HEALTH HISTORY

Today's date: _____

Child's name: _____ Nickname: _____ DOB: _____ Age: _____

Male ☐ Female ☐ School: _____ Hobbies/Pets: _____

Home address: _____
Street and Apt # City, State Zip Code

PARENT/LEGAL GUARDIAN OR RESPONSIBLE PARTY INFORMATION

Name: _____ Social Security # : _____

Date of Birth: _____ Age: _____ Male ☐ Female ☐ Married ☐ Single ☐ Minor ☐

Home address: _____
Street and Apt # City, State Zip Code

Home telephone: _____ Work: _____ Cell: _____

(Please circle the number you would prefer for us to use to contact you.)

Email address: _____
If you provide your email address, we will enroll you in Dental Sesame - our free service for email appointment reminders and online account information. Your email address will be kept private.

Who will be responsible for the charges incurred on this account? _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION
Please present insurance card if you have one

Primary Dental Insurance Company: _____

Employer: _____ Occupation: _____

Policy holder/Subscriber's Name: _____
Last First M

Patient's relationship to Subscriber: Self ☐ Spouse/Partner ☐ Child/Stepchild ☐

Subscriber's ID #: _____ Group #: _____
Subscriber's Date of Birth: _____ Subscriber's SS#: _____

Secondary Dental Insurance Company: _____

Employer: _____ Occupation: _____

Policy holder/Subscriber's Name: _____
Last First M

Patient's relationship to Subscriber: Self ☐ Spouse/Partner ☐ Child/Stepchild ☐

Subscriber's ID #: _____ Group #: _____
Subscriber's Date of Birth: _____ Subscriber's SS#: _____

PINE LAKE DENTAL CARE
CHILD'S MEDICAL HISTORY

Pediatrician's name: _____ **Pediatrician's phone #:** _____

Date of most recent physical exam: _____

✻ Is your child in good health? ☐ Yes ☐ No Under a physician's care? ☐ Yes _____ ☐ No

✻ Is your child taking any over the counter or prescription drugs? ☐ Yes _____ ☐ No

✻ Does your child have any allergies? (Drug, Food, Latex, Seasonal) ☐ Yes _____ ☐ No

Has your child had any of the following?

	YES	NO		YES	NO		YES	NO
ADHD	☐	☐	Epilepsy/seizures	☐	☐	Kidney condition	☐	☐
AIDS/HIV positive	☐	☐	Food allergies	☐	☐	Liver condition/hepatitis	☐	☐
Asthma/breathing problems	☐	☐	Frequent headaches	☐	☐	Mental illness	☐	☐
Autism	☐	☐	Hearing impairment	☐	☐	Pregnancy	☐	☐
Bleeding/Easy bruising	☐	☐	Heart disease/ murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Cancer	☐	☐	High/low blood pressure	☐	☐	Sickle cell disease/ traits	☐	☐
Congenital birth defects	☐	☐	Hives/Rash	☐	☐	Stomach/bowel problems	☐	☐
Diabetes/Endocrine problems	☐	☐	Hospital stay/operations	☐	☐	Tuberculosis (TB)	☐	☐

UPDATE MEDICAL HISTORY AT RECALL APPOINTMENTS

MEDICAL HISTORY UPDATE (to be completed at child's SECOND exam)

Have there been any changes in your child's health since the last dental appointment? ☐ Yes ☐ No

Is your child taking any new medications? ☐ Yes ☐ No If yes, please list: _____

Your signature: _____ Relationship to Patient: _____ Date: _____

Dentist's initials: _____ Date: _____

MEDICAL HISTORY UPDATE (to be completed at child's THIRD exam)

Have there been any changes in your child's health since the last dental appointment? ☐ Yes ☐ No

Is your child taking any new medications? ☐ Yes ☐ No If yes, please list: _____

Your signature: _____ Relationship to Patient: _____ Date: _____

Dentist's initials: _____ Date: _____

MEDICAL HISTORY UPDATE (to be completed at child's FOURTH exam)

Have there been any changes in your child's health since the last dental appointment? ☐ Yes ☐ No

Is your child taking any new medications? ☐ Yes ☐ No If yes, please list: _____

Your signature: _____ Relationship to Patient: _____ Date: _____

Dentist's initials: _____ Date: _____

MEDICAL HISTORY UPDATE (to be completed at child's FIFTH exam)

Have there been any changes in your child's health since the last dental appointment? ☐ Yes ☐ No

Is your child taking any new medications? ☐ Yes ☐ No If yes, please list: _____

Your signature: _____ Relationship to Patient: _____ Date: _____

Dentist's initials: _____ Date: _____

PINE LAKE DENTAL CARE
CHILD'S DENTAL HISTORY

✻ Why did you bring your child to the dentist today? _____

✻ Is this your child's first visit to the dentist? ☐ Yes ☐ No - If No, Date of last dental exam? _____

✻ Type of dental treatment received at last dental visit? ☐ Cleaning(s) ☐ Filling(s) ☐ Emergency Care

✻ Have you been satisfied with your child's previous dental treatment? ☐ Yes ☐ No _____

✻ Has your child been upset or cried for previous dental care? ☐ Yes _____ ☐ No

✻ Is your child anxious about dental visits? ☐ Yes ☐ No

✻ Does he/she usually use laughing gas (nitrous oxide)? ☐ Yes ☐ No

✻ Does your child suck his/her thumb or a pacifier? ☐ Yes ☐ No

✻ Does your child live in an area with fluoride in the water? ☐Yes ☐ No ☐ Unsure

✻ Does your child take fluoride supplements? ☐ Yes ☐ No

✻ Who brushes his/her teeth? _____ Who flosses his/her teeth? _____

✻ How would you describe his/her dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

✻ Do you have any additional concerns/comments or specific interests you would like the dentist to address?

☐ Yes _____ ☐ No

To the best of my knowledge, the above personal, medical and dental information is correct:

I understand that the information that I have given 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 my child may need.

Signature: _____ Date: _____

PARENT/LEGAL GUARDIAN PRINT NAME

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