



Kent Office • 24837 104th Ave SE Suite 200 • 253-850-1234
 Bonney Lake Office • 8412 Meyers Rd. Suite 101 • 253-826-5000

CHILD'S NAME _____ (_____)				
LAST NAME	FIRST NAME	MIDDLE INITIAL	NICKNAME	
ADDRESS	STREET	APT. NO.	CITY	STATE ZIP
AGE	DATE OF BIRTH	SEX	HOME PHONE NUMBER	CELL PHONE NUMBER

FATHER'S INFORMATION		MOTHER'S INFORMATION	
NAME: _____		NAME: _____	
BIRTHDATE: _____	SS*: _____	BIRTHDATE: _____	SS*: _____
DRIVER'S LIC. # _____		DRIVER'S LIC. # _____	
HOME PHONE: _____	CELL # _____	HOME PHONE: _____	CELL # _____
HOME ADDRESS: _____		HOME ADDRESS: _____	
WORK PHONE: _____	E-MAIL: _____	WORK PHONE: _____	E-MAIL: _____
EMPLOYER'S NAME: _____		EMPLOYER'S NAME: _____	

INSURANCE INFORMATION (BE SURE THAT ALL INFORMATION IS LISTED)		
INSURANCE COMPANY NAME & ADDRESS	POLICY HOLDER(SUBSCRIBER)	POLICY NUMBER/GROUP NUMBER
1) _____	_____	_____
2) _____	_____	_____

RELATIVE WHOM WE CAN CONTACT IN THE EVENT OF AN EMERGENCY (NOT LIVING AT SAME HOUSEHOLD)			
NAME _____	(LAST)	(FIRST)	(MIDDLE)
ADDRESS _____			PHONE _____
(NUMBER & STREET)		(CITY)	(STATE) (ZIP)

RESPONSIBLE PARTY _____	RELATIONSHIP TO PATIENT _____	SOC. SEC. # _____
TO KEEP THE COST OF DENTISTRY DOWN, WE ACCEPT ONLY PAYMENT IN FULL THE DAY OF TREATMENT FOR AMOUNTS NOT COVERED BY INSURANCE. PLEASE CHECK ONE OR MORE OF THE FOLLOWING CONVENIENT OPTIONS:		
CASH/CHECK	VISA	MASTERCARD
<input type="checkbox"/> CHECK CARD		
ACCT # _____	EXP. DATE _____	
I HEREBY AUTHORIZE THE OFFICE OF CHILDREN'S DENTAL CARE TO PROCESS PAYEMNT FROM TIME TO TIME AS THE OFFICE SEES FIT TO PAY MY ACCOUNT IN FULL.		
SIGNATURE _____	DATE _____	

THE PARENT THAT COMPLETES THE HEALTH FORMS AND ACCOMPANIES THE PATIENT TO ALL DENTAL APPOINTMENTS IS CONSIDERE FINANCIALLY RESPONSIBLE FOR THE ACCOUNT.

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____ ADDRESS _____
 WHO DOES THIS CHILD RESIDE WITH? _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:
 I CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF _____ (PATIENT NAME) AND GRANT CONSENT FOR BRAD HWANG, D.D.S. & ASSOCIATES TO TREAT _____ (PATIENT NAME). I AUTHORIZE ROUTINE DENTAL PROCEDURES FOR MY CHILD. IF I ACCEPT THE PROPOSED TREATMENT PLAN I ALSO AGREE TO THE USE OF ANESHTETICS AND PREMEDICATIONS CONSIDERED NECESSARY OR ADVISABLE BY THE DENTIST FOR THE COMFORT AND WELL BEING OF THE CHILD.

I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT. CHANGES SHOWN BY STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS PROTESTED IN WRITING WITHIN THIRTY DAYS OF BILLING DATE. IN THE EVENT IT SHOULD BECOME NECESSARY TO PLACE FOR COLLECTION AND UNPAID BALANCE DUE FOR SERVICES RENDERED TO ME OR MY FAMILY, I/WE AGREE TO PAY COLLECTION FEES, AND SHOULD LEGAL ACTION BE FILED, REASONABLE ATTORNEY FEES, FILING FEES AND ANY OTHER COSTS THE COURT DETERMINES PROPER.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD BECAUSE OF ANY INSURANCE COVERAGE OR THE PENDENCY OF CLAIMS THEREON, AND ALL PROCEEDS OF INSURANCE ASSIGNED TO THIS OFFICE WHERE APPLICABLE, BUT WITHOUT THEIR ASSUMING RESPONSIBILITY FOR THE COLLECTION THEREOF. (A COPY OF THIS AGREEMENT IS AS VALID AS THE ORIGINAL AS WELL AS ANY ELECTRONIC OR SCANNED COPIES)

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ AND AGREE TO THE CONDITIONS SET FORTH. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT AT THE TIME YOU SIGN. READ IT TO PROTECT YOUR LEGAL RIGHTS.

SIGNATURE _____ DATE _____



CHILDREN'S DENTAL CARE

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MEDICAL HISTORY AND INFORMATION

CHILD'S PHYSICIAN: _____ DATE OF LAST MEDICAL EXAM: _____

PHYSICIAN'S PHONE NUMBER: _____

1. IS YOUR CHILD:

IN GOOD HEALTH? YES NO UNDER A PHYSICIAN'S CARE? YES NO

TAKING MEDICINE(S)? YES NO

MEDICINE(S): _____

DOSE(S): _____

2. HAS YOUR CHILD HAD ANY HISTORY OF ILLNESS OR DIFFICULTY WITH THE FOLLOWING? (CIRCLE ALL THAT APPLY)

- | | | | | |
|---------------------|---------------|----------|-------------------|-------------------|
| ANEMIA | ASTHMA | AUTISM | BEHAVIOR PROBLEMS | CANCER |
| CEREBRAL PALSY | TUMOR | DIABETES | DRUG REACTION | ENDOCRINE |
| HEARING IMPAIRMENT | HIV + OR AIDS | LIVER | HYDROCEPHALUS | HEADACHES |
| LEARNING DISABILITY | HEPATITIS | KIDNEY | SPEECH DISORDER | KIDNEY |
| DEVELOPMENTAL DELAY | SEIZURES | THYROID | BLEEDING DISORDER | VISION IMPAIRMENT |
- HEART DEFECT, DISEASE, OR MURMUR

3. DOES YOUR CHILD HAVE ANY ALLERGIES? (DRUG, FOOD, LATEX, POLLEN) SPECIFY: _____

4. HAS THE CHILD BEEN HOSPITALIZED OR REQUIRED SURGERY? IF YES, DESCRIBE YES NO

DATE(S): _____

CONDITION(S): _____

5. WHICH BEST DESCRIBES YOUR CHILDS PERSONALITY? (CIRCLE ONE) NORMAL SHY NERVOUS DIFFICULT

DENTAL HISTORY

PREVIOUS OR REFERRING DENTIST: _____ DATE OF LAST DENTAL VISIT: _____

DENTIST'S ADDRESS: _____

WHAT IS THE MAIN CONCERN OF YOUR CHILD'S DENTAL HEALTH: _____

1. HAS YOUR CHILD COMPLAINED ABOUT DENTAL PROBLEMS? YES NO

2. ANY UNHAPPY DENTAL EXPERIENCES? YES NO

3. ANY INJURIES TO MOUTH, TEETH, OR HEAD? IF YES, DESCRIBE: YES NO

4. ANY MOUTH HABITS? (CIRCLE ALL THAT APPLY) NURSING BOTTLE THUMB SUCKING PACIFIER

MOUTH BREATHING NAIL BITING

5. ARE THE TEETH BRUSHED? OCCASIONALLY ONCE DAILY MORE OFTEN

6. ARE THE TEETH FLOTTED? OCCASIONALLY ONCE DAILY MORE OFTEN

7. DOES PARENT ASSIST THE CHILD WITH BRUSHING? YES NO

8. DOES PARENT ASSIST THE CHILD WITH FLOSSING? YES NO

9. IS FLUORIDE TAKEN IN ANY FORM (OTHER THAN TOOTHPASTE)? YES NO

10. ANY DIFFICULTY WITH THE JAW JOINTS, "TMJ"? (CIRCLE ONE) NONE CLICKING POPPING

PAINFUL OPENING DIFFICULTY

PARENT COMMENT: (IS THERE ANYTHING ELSE ABOUT YOUR CHILD YOU THINK WE SHOULD KNOW?)

CHILD'S NAME _____ RELATIONSHIP TO PATIENT: _____

YOUR SIGNATURE: _____ DATE: _____ REVIEWED BY: _____