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253.851.9171
kvinslanddentistry.com

Child Registration

Date: _____ Referred by: _____

Child's Name: _____
(First, middle, last)

Nickname: _____ _____ Date of Birth: _____

Parents' Name: _____

Address: _____

City: _____ _____State:_____ Zip: _____

Home Phone: _____ Email: _____

Mother Cell#: _____ Father Cell#_____

School: _____

Person responsible for the account: _____

Insurance Information

Primary Insurance: _____

Subscriber: _____ Employer: _____

ID#:_____ Date of Birth:_____

Secondary Insurance: _____

Subscriber: _____ Employer: _____

ID#:_____ Date of Birth:_____

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Information for Emergency Treatment

Date of last dental examination? _____

Are there any dental concerns at this time? _____

Date of last medical examination? _____

Does the child have or ever had any of the following?	YES	NO
Anemia	_____	_____
Diabetes	_____	_____
Hepatitis	_____	_____
Allergies	_____	_____

If "yes," please list: _____

_____

Allergic to penicillin	_____	_____
Allergic to local anesthetic	_____	_____
Abnormal heart condition	_____	_____
Abnormal bleeding from a cut	_____	_____
Rheumatic fever	_____	_____
Heart Murmur	_____	_____
Is your child under the care of a physician now?	_____	_____
Is any mediation being taken now?	_____	_____

If "yes," please list: _____

Any other physical conditions we should be aware of? _____

_____

Name of Physician: _____

Information provided by (signature): _____

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Authorization to Release Health Care Information

Patient's name:_____Date of Birth:_____

I request and authorize _____ to release health care information of the patient name above to:

Kvinsland Dentistry
5122 Olympic Dr. A-201
Gig Harbor, WA 98335

info@kvinslanddentistry.com | 253.851.9171

This request and authorization applies to:

- ☐ Health care information relation to the following treatment, condition, or dates of treatment:
  _____
- ☐ All health care information
- ☐ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to relase all health care information relating to such diagnosis, testing, or treatment.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

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Acknowledgement of Privacy Practices

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 providers *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 the *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 you are not required to agree to my requested restrictions, but if you do agree then you 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

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Welcome to Kvinsland Dentistry! Thank you for selecting our office for your dental care. We are committed to providing excellent dental care with concern for your personal needs. The following information will acquaint you with our office financial policies and allow us to provide a high quality of service to you.

- **Insurance Benefits:** We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payments level that is quoted nor have information on benefits used in any other dental professionals office if used within your plan year. Any balances remaining after your insurance pays, are due within 15 days of billing.
- **Payment:** Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patient CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. A service charge of 1.0% per month (12% APR) or $8.00, whichever is greater, will be added to your account for balances due past 30 days.
- **Minor Patients:** The adult accompanying the minor (under the age of 18) is responsible for full payment of the services provided. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.
- **Missed Appointments:** For the courtesy of other patients that are waiting for appointment times, please be aware that we require a 24 hour notice to change or cancel an appointment to avoid a charge.

PAYMENT OPTIONS:

1.
2. Complete payment in advance: For qualified patients we offer a **5% bookkeeping courtesy reduction** when the total amount for all phases of your proposed treatment plan is paid in full by **cash or check** BEFORE the first appointment.
3. We accept: **VISA, MASTERCARD, CASH, OR CHECK**
4. Healthcare Financing: Upon approval of credit, including a 12 month option.

CONSENT FOR CARE:

I request the consultation services of Eric Kvinsland, DDS or Austin Neal, DDS. I authorize the doctor to take any necessary x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of treatment needs. I understand this may include consultation with my physician or other practice specialists. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

_____ _____

Date Patient Name: Printed

_____

Patient Signature (Parent if under 18)