Cook Pediatric Dentistry
1901 South Union Avenue, Suite B6005
Tacoma, Washington 98405
253-627-5470

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Cook Pediatric Dentistry. The Statement 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 office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cook Pediatric Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my child's protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐	**YES**	☐	**NO**
SPOUSE ONLY	☐	**YES**	☐	**NO**
OTHER ***(PLEASE SPECIFY):***	☐	**YES**	☐	**NO**

_____
Name of Patient

_____
Date

_____
Personal Representative/Please Print

_____
Signature of Personal Representative

_____
Relationship of Personal Representative to Patient

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained		
PROVIDED PRIOR TO TREATMENT:	☐ **YES** ☐ **NO**	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):

MEDICAL HISTORY INFORMATION

COOK PEDIATRIC DENTISTRY
SPECIALISTS IN CHILDREN'S DENTISTRY
1901 S UNION AVENUE SUITE B6005 TACOMA, WASHINGTON 98405-1806

Patient's Name: _____ Patient's Nickname: _____

Age: _____ Sex: _____ Date of Birth: _____

Child's Physician: Dr._____ Date of last medical exam: _____

1. Is your child:

In good health: Yes ☐ No ☐ Taking medication(s)? Yes ☐ No ☐

Under active medical care? Yes ☐ No ☐ Medicine(s): _____

Explain: _____ Dose(s): _____

2. Has your child had any history of illness or difficulty with the following? (Circle all that apply and explain below)

ADHD	ANEMIA	ASTHMA	AUTISM	BLEEDING DISORDER	CANCER
CEREBRAL PALSY	CLEFT LIP	CLEFT PALATE	DEVELOPMENTAL DELAY	DIABETES	DRUG REACTION
ENDOCRINE SYSTEM	HEART DEFECT, DISEASE, OR MURMUR	HEARING IMPAIRMENT	HEADACHES	HEPATITUS	HIV+ OR AIDS
HYDROCEPHALUS	KIDNEY	LEARNING DISABILITY	LIVER	LUNG DISEASE	SEIZURES
SPEECH DISORDER	THYROID	TUBERCULOSIS	TUMOR	VISION IMPAIRMENT	NONE

3. Please explain each item circled above:

_____

_____

4. Allergies? Yes ☐ No ☐ if yes, describe: (i.e. drug, food, latex, etc.)_____

5. Has your child been hospitalized or required surgery? Yes ☐ No ☐ If Yes, describe below:

Date(s): _____

Condition(s):_____

6. Which best describes your child's personality? (Circle one)

FRIENDLY	SHY	NERVOUS	STRONG WILLED

7. Additional information: In the space below, please indicate any special concern or provide additional medical information that you think may be useful in providing dental care for your child.

_____

_____

Signature of Parent or Legal Guardian:_____ Printed Name_____

Emergency contact:_____

Relationship to patient:_____ Phone:_____

I agree to diagnostic procedures and dental treatments as found necessary and recommended by Daniel H. Cook D.D.S., M.S. and his associates for the above named patient. I authorize the release of any information relative to any insurance claim and authorize payment of my group insurance benefits, otherwise payable to me, to Cook Pediatric Dentistry, L.L.C.

I understand that I am financially responsible to the dentist for any charges not payable by the dental insurance program.

I have informed the office of Cook Pediatric Dentistry of all applicable dental insurance that covers my child.

Date _____ _____ _____

Signature of Parent of Legal Guardian Printed Name

_____ Dental Assistant reviewing history