Camille Sata, D.M.D.
DENTISTRY FOR CHILDREN
7900 E. GREENLAKE DRIVE N.
SUITE 210
SEATTLE WA 98103
206·522·1565
206·522·4064 FAX

WELCOME AND THANK YOU FOR SELECTING OUR OFFICE!

Our specialty practice is committed to providing high quality dental care for children. As we strive to introduce children to dentistry in a positive manner, using kindness and understanding, we will try to make your visit a pleasant and comfortable one. Our goal is to teach parents and children good oral care and prevention. Good oral habits established at a young age will help your child have a beautiful smile that lasts a lifetime.

General Office Policies:

1. Parents are welcome and encouraged to accompany their children in the treatment area.

   Cooperative behavior and doctor/patient bonding are best achieved when the dentist has your child's full attention. For this reason, parents may be asked to leave the treatment area during ***restorative procedures*****,** if Dr. Sata feels it may be helpful to complete treatment successfully. Dr. Sata welcomes any input you may have that may help your child in accomplishing any treatment they may need.

2. Prior to beginning any treatment, an explanation of the recommended services will be presented. Estimates of fees involved may be discussed with the receptionist.

3. Payment for services rendered is due at each visit. The portion of treatment that is not covered by dental insurance is due at the time of treatment. **Any amounts collected today are only estimates based on information provided by your insurance company. Final determination will be made when your claim is received**. You are financially responsible for any charges not paid by your dental insurance program.

4. We require 24 hours notice if you need to cancel or change an appointment. We reserve the right to inactivate a patient for broken appointments.

If you have any questions, please feel free to discuss them with us promptly. We will make every effort to avoid misunderstandings, and to preserve a positive relationship.

Thank you for selecting our office. We are committed to excellence in pediatric dentistry and look forward to a long-lasting friendship with you and your family.

Patient Registration

Child's Name _____ Date of birth _____
last first middle

.
Home address_____

City_____ State _____ Zip code _____ home # ( ) _____

Child lives with_____ Email _____

Marital status of parent(s): single married widowed separated divorced other

Names and birth dates of other children in the family: _____

Parent's Name _____ Date of Birth _____
last first middle

Address if Different from Child _____

SS# _____ Cell phone # _____ Employer_____

Dental Insurance Company _____ Insurance phone _____

Ins. ID # _____Group #_____ Work phone #_____

Parent's Name _____ Date of Birth _____
last first middle

Address if Different from Child _____

SS# _____ Cell phone # _____ Employer_____

Dental Insurance Company _____ Insurance phone _____

Ins. ID # _____Group #_____ Work phone #_____

Other Parent's Name _____ Date of Birth _____
last first middle

Address if Different from Child _____

SS# _____ Cell phone # _____ Employer_____

Dental Insurance Company _____ Insurance phone _____

Ins. ID # _____Group #_____ Work phone #_____

Who can we thank for referring you to our office? _____

Camille Sata, DMD – Dentistry for Children
Medical History Questionnaire

Please complete the following questions. This information will help us to perform optimum dental treatment for your child. All answers are confidential and will become part of your child's permanent dental record.

Child's Name: _____ Nickname: _____
First Middle Last

Age:___ Birthdate: _____ Sex: ☐ Female ☐ Male Place of Birth _____

Attends which school: _____ Grade: _____

How would you describe your child's personality? _____

_____

Is your child in good health: ---------- ☐ Yes ☐ No

Is your child under the care of a physician? ---------- ☐ Yes ☐ No

If yes, what is the condition being treated: _____

Name of Pediatrician or Family Physician: _____

Address: _____ Phone: _____

Date of last physical examination: _____

Has your child's physician or a cardiologist informed you of your child's need to be placed on prophylactic antibiotic therapy prior to his/her dental procedure? ---------- ☐ Yes ☐ No

If yes, any specific recommendations? _____

Did your child have trouble at birth or during the early years? ---------- ☐ Yes ☐ No

Please describe: _____

Has your child had any serious injury or illness? ---------- ☐ Yes ☐ No

Please describe: _____

Has your child ever been hospitalized? ---------- ☐ Yes ☐ No

Please describe: _____

Does your child have any problems with recurrent headaches? ---------- ☐ Yes ☐ No

Please describe: _____

Has your child had a history of Temporo-Mandibular Joint Dysfunction? ---------- ☐ Yes ☐ No

Is your child receiving any medication? ---------- ☐ Yes ☐ No

List medications & conditions treated: _____

_____

Have you ever been told by a physician that your child has hepatitis? ---------- ☐ Yes ☐ No

Does your child have asthma? ---------- ☐ Yes ☐ No

Is your child up to date on his/her immunizations? ---------- ☐ Yes ☐ No

Does your child have any physical or mental disabilities ---------- ☐ Yes ☐ No

If yes, please describe: _____

Does your child have a learning disorder or a behavior problem's? ---------- ☐ Yes ☐ No

Please describe: _____

Please check the box(s) if your child has a history of the following conditions:

☐ Heart Murmur	☐ Prolonged Bleeding	☐ HIV
☐ Fainting	☐ Dizziness	☐ Behavioral Problems
☐ Diabetes	☐ Frequent Headaches	☐ Heart Trouble
☐ Asthma	☐ Hepatitis	☐ Kidney Problems
☐ Rheumatic Fever	☐ Epilepsy	☐ Cerebral Palsy
☐ Liver Problems	☐ Mental Disability	☐ Congenital Birth Defects
☐ Hearing Loss	☐ Eyesight Difficulties	☐ Cancer
☐ Infections	☐ Speech Impairment	☐ Bone Disorder
☐ Learning Problems	☐ Anemia	☐ Organ Transplant
☐ Asperger's Syndrome	☐ Autism	☐ Other_____

☐ My child has no known history of any of these conditions.

Please comment on above checked items: _____

_____

Has your child ever experienced an unusual reaction (allergy or sensitization) to any of the following? ☐ Yes ☐ No

If yes, please check the box below:

☐ Aspirin	☐ Pollen	☐ Amoxicillin
☐ Sulfa Drugs	☐ Latex	☐ Codeine
☐ Dental Local Anesthetic	☐ Penicillin	☐ General Anesthetic
☐ Food (list below)	☐ Erythromycin	
☐ Dust	☐ Ataraxic (Tranquilizers)	

☐ Other: _____

Please comment on above items: _____

_____

Please note any additional comments/concerns that you may have: _____

_____

I certify that the above information is complete and accurate.

Parent/Guardian Signature: _____ Date: _____

Reviewed by: Dentist's Signature: _____ Date: _____

STATEMENT OF PRIVACY PRACTICES

Camille Sata, DMD – Dentistry for Children

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Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and 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 and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, dental 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 your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail mes sages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an 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.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

Camille Sata, DMD – Dentistry for Children

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Camille Sata, DMD. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) 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.

Camille Sata, DMD reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

1. Spouse only → ☐ YES ☐ NO

OR

2. Any member of my immediate family (i.e. Spouse, Children, etc.) → ☐ YES ☐ NO
3. Any member of my extended family: (i.e. Parents, Grandparent) → ☐ YES ☐ NO
4. Other: → ☐ YES ☐ NO

Patient Name (print): _____ Patient Signature: _____

Patient Personal Representative: (print): _____ Rep Phone _____

Personal Representative's Signature: _____ Date: _____

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment? ☐ YES ☐ NO Date Statement Provided: _____

Reason for not obtaining patient signature:

- ☐ Needed more time to review Statement of Privacy Practices
- ☐ Wanted to consult another person before signing
- ☐ Physically unable to sign
- ☐ No reason offered
- ☐ Other: _____

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Consent for Treatment

1. The undersigned hereby authorizes the dentist, and her staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs.

2. I also authorize the dentist to perform all recommended treatment mutually agreed upon by me (parent/guardian) and to use the appropriate medication and therapy indicated for such treatment. In addition, I understand that using anesthetic and/or sedation agents embodies a certain risk.

3. Furthermore, I authorize and consent that the dentist choose and employ such assistance as deemed fit to provide the recommended treatment. If any treatment should vary from that being contemplated, and if there is no reasonable opportunity for additional explanation and authorization, the parent or guardian further authorizes Dr. Camille Sata to proceed with such treatment she considers advisable based on her opinion and judgment.

4. In Pediatric Dentistry, as in all other healthcare treatment, there can be no guarantees of particular outcomes. The anticipated benefits are based on results from treating similar conditions and may vary depending on patient cooperation, individual physical and psychological differences, and a number of other factors.

Patients Name: _____ _____ _____

Last First Middle

Signature of Parent or Guardian _____ Date _____

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OFFICE FINANCIAL POLICY

Payment for services rendered is due in full at each visit. This office does not offer private payment plans.

Payment Options:

- Cash or Check
- Credit Cards: MasterCard, Visa

Dental Insurance:

- If insurance benefits are assigned to the dentist, the portion of treatment that is not covered by dental insurance is due at the time of treatment. If for any reason, your insurance company does not cover services rendered, or does not pay their portion within 60 days from the date of service, you are responsible for payment at that time.
- Past due accounts may be subject to a late fee service charge (1% per month, at 12% APR, after 60 days) and/or assignment to a collection agency.

Assignment of Insurance Benefits

I authorize the attending dentist, Dr. Camille Sata, to release any information relating to this claim, and the insurance company to make payment of the dental benefits directly to the attending dentist. I understand that I am financially responsible to the dentist for any charges not payable by the dental insurance program.

Please feel free to call us at any time if you have any special concerns regarding your child's dental health care or account status. Please sign below to indicate you have read and understand our office financial policy.

I have read this Financial Policy. I understand and agree to this Financial Policy.

Patient's Name(s) Relationship

_____

_____

_____

_____

_____

_____

Signature of Responsible Party _____Date _____

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OCR NOTICE OF NONDISCRIMINATION

Notice posting as required under federal law Source: HHS Office for Civil Rights

Camille Sata, DMD – Dentistry for Children complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Camille Sata, DMD – Dentistry for Children does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Camille Sata, DMD – Dentistry for Children:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages If you need these services, contact our office.

If you believe that Camille Sata, DMD – Dentistry for Children has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Camille Sata, DMD 7900 E Greenlake Drive N, Suite 210, Seattle, WA 98103
Office: (206)522-1565 Email: office@drcamillesata.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our office at (206)522-1565 is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue SW. Room 509F, HHH Building Washington, DC 20201 Toll Free: 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Washington State Language
Translation Assistance

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spanish: Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio odontológico que suministramos.

Chinese: 我们将有序地做到提供免费的语言服务使我们能听懂英语不好的人向我们咨询有关牙齿护理

Vietnamese: Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Korean: 저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

Russian: Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

Tagalog: Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

Ukrainian: Ми вживаємо необхідні заходи, щоб надати безкоштовні послуги перекладача для спілкування мовами, з якими ми стикаємось в нашій практиці з клієнтами, які не володіють англійською мовою достатньо, щоб обговорити з нами стоматологічні послуги, які ми надаємо.

Mon-Khmer, Cambodian:
យើងខ្ញុំនឹងចាត់វិធានការសមយេតុផលយដើមបីផដល់ជូននូវយសវាជុំនួយភាសាយោយឥតគិតថ្លៃ ដល់អ្នកនិយាយភាសាដដលយយើង ខ្ញុំចង់សាដ ប់យៅកនញ្ចកការអ្ររតតរបស់យយើងខ្ញុំ និងអ្នកដដលនិយាយភាសាអ្ង់យគែសមិនសូរបានលអកនញ្ចកការនិយាយមកកាន់យយើងខ្ញុំអ្ុំពីការដលទមាុំ តំយមេញដដលយយើងខ្ញុំកុំពុ ងផដល់ឲ្យ។

Japanese: 実際に練習の中で耳にするく可能性がある言語を話す人々で、弊社が提供している歯科治療について、英語がそ れほど上手でない人々に、無償の言語支援サービスを提供するために合理的な措置を講じるつもりです

Amharic: አገልግሎት በምንሰጥበት ወቅት ልንሰማቸው የምንችል የተለያዩ ቋንቋዎችን ለሚናገሩና ስለምንሰጠው የጥርስ ሕክምና ለመነጋገር የሚያስችል በቂ የእንግሊዝኛ ቋንቋ ችሎታ ለሌላቸው ሰዎች የቋንቋ ድጋፍ አገልግሎት ከክፍያ ነጻ ለመስጠት ተገቢ የሆኑ እርምጃዎችን እንወስዳለን፡፡

Cushite: Wayita hojjii keenyatti Afaanota garaa garaagaraa namoota dubbatani fi tajaajila yaalaa nuti kenninuuf kan nu dandeessisu namoota dandeettii Aaan Ingilliffaa gahaa ta'e hin qabneef deeggarsa afaanii kanfaltii irraa bilisa ta'e kennuudhaaf tarkaanfii bu'a qabeessa ta'e ni fudhanna.

Arabic: سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق بر عاية الأسنان التي نقدمها.

Panjabi: ਅਸੀਂ ਉਨ੍ਹਾਂ ਵਿਅਕਤੀਆਂ ਨ੍ਹੰ , ਵਿਹੜੇ ਉਹ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹਨ੍ ਵਿਹੜੀਆਂ ਅਸੀਂ ਆਪਣੇ ਅਵਭਆਸ ਵਿੱਚ ਸੁੰਭਾਤ ਰ ਪ ਵਿੱਚ ਸੁਣਨ੍ਾ ਚਾਹੁੰਦੇ ਹਾਂ ਅਤੇ ਵਿਹੜੇ ਸਾਡੇ ਦੁਆਰਾ ਪਰਦਾਨ੍ ਕੀਤੀ ਿਾਣ ਿਾਲੀ ਡੈਂਟਲ ਦੇਖਭਾਲ ਦੇ ਬਾਰੇ ਸਾਡੇ ਨ੍ਾਲ ਸਹੀ ਤਰਹਾਂ ਅੰਗਰੇਜੀ ਨ੍ਹੀਂ ਬੋਲਦੇ, ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਿਾਂ ਪਰਦਾਨ੍ ਕਰਨ੍ ਲਈ ਉਵਚਤ ਕਦਮ ਚਿੱਕੁਾਂਗੇ।

German: Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Laotian: ພວກເຮົ າຈະໃຊ້ ຂ ້ ນຕອນທ ີ່ ເໝາະສົ ມ ເພ ື່ ອໃຫ ້ ບ ໍ ລ ິ ການຊ ່ ວຍເຫ ຼ ືອ ດ ້ ານພາສາບ ໍ ່ ເສຍຄ ່ າເກ ັ ບ ນຜ ້ ທ ີ່ ເ ວ ົ ້ າພາສາທ ີ່ ພວກເຮົ າອາດຈະໄດ ້ ຍ ິ ນຢ ີ່ ໃນການຜ ິ ຊ ້ ອມຂອງພວກເ ຮ ົ າ ເຜ ້ ທ ີ່ ບ ໍ ່ ເ ວ ົ ້ າພາສາອ ງກ ິ ດ ໄດ ້ ດ ພ ່ ເພ ື່ ອລ ິ ນກ ບພວກເຮົ າກ ່ ຽວກ ບການບ ໍ ່ ງ ເຫ ຼ ຽ ເ ວ ົ ້ ອທ ີ່ ພວກເຮົ າກ ່ າ ລ ງ ດ ໃຫ ້