NW PEDIATRIC DENTISTRY

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Patient Name: ______________________
Birth Date: ______________ **M / F:** ________
Main Contact #: ______________________
Main Email: ______________________
Address: ______________________
____
Father: ______________________
Mother: ______________________
Insurance & Phone #: ______________________
Subscriber: ______________________
Subscriber ID/SSN: ______________________
Subscriber DOB: ______________________
Employer: ______________________
Group #: ______________________
Pediatrician: ______________________
How did you find us?: o **Insurance Listing**
o **Existing Patient (who)** ______________
o **Online (search, Google, Red Tricycle)** o **Other**

MEDICAL HISTORY:

1) Is your child
   A) Taking medications? ______________________
   B) Under care for on-going conditions? ______________________
   C) Hospitalized in past? ______________________

2) Check any of the following conditions for which your child has been treated in the past (5) years:

O Anemia / Blood Disorder	O Asthma	O Autism
O Behavioral Issues	O Cancer / Tumors	O Developmentally Delayed
O Diabetes	O Endocrine	O Headaches
O Hearing Impairment	O Heart Defects, Disease or Murmur	O Hepatitis
O HIV or AIDS	O Hydrocephalus	O Kidneys
O Learning Disability(ies)	O Lung Disease	O Liver Disorder
O Seizure / Fainting / Dizziness	O Speech Disorder / Therapy	O Thyroid
O Vision Impairment	O **My child has no medical conditions**	

3) Allergies: Food / Drug / Latex / Seasonal
   Please explain: ______________________

4) Present Dental History: Has your child
   A) Mentioned any dental problems (Y/N)? ______________________
   B) Had any unfavorable dental experiences (Y/N)? ______________________
   C) Had any mouth / teeth / head injuries (Y/N)? ______________________
   D) Previous Dentist, City: ______________________

FINANCIAL RESPONSIBILITY:

NW Pediatric Dentistry makes access to care easy and affordable by participating with most dental insurance plans. For your convenience, we send a dental claim to your insurance plan electronically the day your child receives treatment. Your insurance company is obligated to pay the claim within 30 days from the date of submission. At that point, we consider the outstanding charges billable to you, the consumer.

A copy of your Visa or Mastercard and your driver's license will be placed on file and will be processed on all unpaid claims after 30 days. You will be emailed a statement showing the unpaid claims and the credit card receipt for your records.

o **I understand that I will be charged for all unpaid claims after 30 days. Please initial** __________

By signing below, you consent to your child's treatment and your financial obligation to NW Pediatric Dentistry.

______________________________ ______________
Parent Signature Date