



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?: Insurance Listing

Existing Patient (who) _____

Online (search, Google, Red Tricycle) 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:

<input type="radio"/> Anemia / Blood Disorder	<input type="radio"/> Asthma	<input type="radio"/> Autism
<input type="radio"/> Behavioral Issues	<input type="radio"/> Cancer / Tumors	<input type="radio"/> Developmentally Delayed
<input type="radio"/> Diabetes	<input type="radio"/> Endocrine	<input type="radio"/> Headaches
<input type="radio"/> Hearing Impairment	<input type="radio"/> Heart Defects, Disease or Murmur	<input type="radio"/> Hepatitis
<input type="radio"/> HIV or AIDS	<input type="radio"/> Hydrocephalus	<input type="radio"/> Kidneys
<input type="radio"/> Learning Disability(ies)	<input type="radio"/> Lung Disease	<input type="radio"/> Liver Disorder
<input type="radio"/> Seizure / Fainting / Dizziness	<input type="radio"/> Speech Disorder / Therapy	<input type="radio"/> Thyroid
<input type="radio"/> Vision Impairment	<input type="radio"/> 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: _____

CANCELLATION POLICY:

If you are unable to keep your appointment, please notify our office 24 hours prior to your scheduled time. A fee of \$25.00 will be charged per child for missed appointments without 24 hours notice.

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.

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