DAVID R. ATHERTON, D.D.S

BEAR CREEK PROFESSIONAL CENTER
17130 AVONDALE WAY N.E., SUITE 118
REDMOND, WASHINGTON 98052
(206) 869-1830

Dentistry for Children and Young Adults

Patient Information:

NAME	SEX	DOB MM/DD/YY	AGE
ADDRESS	CITY		ZIP
PHONE	CELL #		
EMAIL FOR APPOINTMENT REMINDERS	OTHER FAMILY MEMBERS SEEN IN OUR OFFICE		
NAME OF PREVIOUS DENTIST	LAST DENTIST VISIT		
PERSON TO CONTACT IN CASE OF EMERGENCY			
HOW DID YOU HEAR ABOUT OUR OFFICE?			

Parent Information:

PARENTS' NAME(S)		
ADDRESS (If different from above)	CITY	ZIP
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED		

YOUR INFORMATION (employment)

NAME OF EMPLOYEE	DOB MM/DD/YY
COMPANY NAME & ADDRESS	
* EMPLOYEE SS #	
WORK PHONE #	

SPOUSE INFORMATION (employment)

NAME OF EMPLOYEE	DOB MM/DD/YY
COMPANY NAME & ADDRESS	
EMPLOYEE SS #	
WORK PHONE #	

YOUR INSURANCE

INSURANCE CO.
ADDRESS
GROUP #
ID #

SPOUSE INSURANCE

INSURANCE CO.
ADDRESS
GROUP #
ID #

*If SS # is not given, cash only will be required at the time of services.

INSURANCE CLAIMS will be submitted providing ALL pertinent information has been provided to our office. Please contact your insurance company directly if you have questions about your dental benefits. Upon payment of the claim by the insurance company, the responsible party will be billed for the account balance. However, the RESPONSIBLE PARTY WILL BE HELD ACCOUNTABLE FOR ALL FEES, regardless of insurance coverage. Accounts are due in full upon receipt of statement, unless prior financial arrangements have been made. A $25.00 charge will be made for each broken appointment unless 24 hours notice is given.

** PLEASE NOTE THE PERSON BRINGING A CHILD IN FOR TREATMENT WILL BE CONSIDERED THE RESPONSIBLE PARTY AND WILL BE BILLED AS SUCH. OUR OFFICE WILL NOT BILL ANY OTHER PARTY.

I agree to the financial terms as stated above:

SIGNATURE _____ DATE _____

Does your child have or, ever had, any of the following treatments or conditions:

	YES / WHEN?	NO	UNSURE		YES / WHEN?	NO	UNSURE
Anemia				Heart Condition/Murmur			
Asthma				Hepatitis			
Attention Deficit Disorder				HIV (Aids)			
Behavior Counseling				Hypertension			
Birth Defects				Kidney Disease			
Cancer				Mental Retardation			
Cerebral Palsy				Psychiatric Problems			
Delayed Speech Development				Rheumatic Fever			
Diabetes				Sickle Cell Anemia			
Epilepsy/Seizures				Xray Treatment (non-dental)			
Hearing Loss/Impairment							

1. Are there any Conditions other than those mentioned above that we should be aware of?
2. Is your child allergic to any medications or foods?
3. Is your child currently taking any medications/ what for?
4. Has your child ever been hospitalized / what for?
5. Has your child ever had difficulty with general anesthesia / describe?

DENTAL HISTORY

Date of last visit to dentist	
What was child treated for (i.e., cleaning, xrays, fillings, etc.)	
Any injuries to mouth, teeth or head	
Oral habits (i.e., thumb sucking, pacifiers, nursing, bottle, etc.)	
Has your child had previous dental xrays/ with whom?	Phone #
Do you live in an area with fluoridated water?	
Does your child currently take fluoride supplements?	
Has your child had any unhappy dental experiences? Please explain	
Child's Physician And Or Clinic	Phone #
Last Physical Exam	

INFORMED CONSENT

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize Dr. Atherton and the dental staff under his direction to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist group insurance benefits otherwise payable to me.

Signature of Parent or Guardian Date