Dr. Stephen Sadler DDS
Redmond Pediatric Dentistry

BEAR CREEK PROFESSIONAL CENTER
17130 AVONDALE WAY N.E., SUITE 118
REDMOND, WASHINGTON 98052
(425) 869-1830 Fax: (425)869-9836

Patient Information:

CHILD'S NAME		GENDER	DOB	AGE
CHILD'S ADDRESS		CITY	ZIP CODE	
HOME PHONE #	CELL PHONE #	CELL PHONE CARRIER: For appointment confirmations only AT&T ☐ VERIZON ☐ T-MOBILE ☐ OTHER		
EMAIL ADDRESS:		OTHER FAMILY MEMBERS SEEN IN OUR OFFICE		
WHO IS ACCOMPANING THE CHILD TODAY?		RELATIONSHIP TO CHILD?		
PERSON TO CONTACT IN CASE OF EMERGENCY, NAME, AND PHONE #				
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				

Parent Information:

PARENTS / STEPPARENT / GUARDIAN'S NAMES:		
ADDRESS: (If different from above)	CITY	ZIP
MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐		

Parent Information (Primary Insurance)

NAME OF PARENT	DOB
EMPLOYER	
EMPLOYEE SS #	
WORK PHONE #	

DENTAL INSURANCE CO.
ADDRESS
ID #
GROUP #

Spouse Information or (Secondary Ins. if applies)

NAME OF PARENT	DOB
EMPLOYER	
EMPLOYEE SS #	
WORK PHONE #	

DENTAL INSURANCE CO.
ADDRESS
ID #
GROUP #

Insurance claims will be submitted providing all pertinent information has been provided to our office. I authorize and request my insurance company to pay dental benefits directly to the dentist and or facility. 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. Accounts are due in full upon receipt of the statement unless prior financial arrangements have been made.

THE RESPONSIBLE PARTY WILL BE HELD ACCOUNTABLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE!
**** 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. ****

A $25.00 charge will be made for each broken appointment unless 24 hours' notice is given.

I agree to the financial terms as stated above:

_____

Signature of Parent or Guardian **Date**

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

	YES / WHEN?	NO	UNSURE		YES / WHEN?	NO	UNSURE
Asthma	☐	☐	☐	Heart Condition/Murmur	☐	☐	☐
Attention Deficit Disorder (ADD)	☐	☐	☐	Hepatitis	☐	☐	☐
Autism	☐	☐	☐	Blood clotting disorders	☐	☐	☐
Behavior / Psychiatric Problems	☐	☐	☐	Hypertension	☐	☐	☐
Birth Defects	☐	☐	☐	Kidney Disease	☐	☐	☐
Cancer	☐	☐	☐	Intellectual disability	☐	☐	☐
Cerebral Palsy	☐	☐	☐	Sickle Cell Anemia	☐	☐	☐
Delayed speech development	☐	☐	☐	Hearing Loss/ impairment	☐	☐	☐

1. Does your child have any other Conditions other than those mentioned above that we should be aware of?	
2. Is your child **allergic to any medications or foods**?	3. Latex allergy: Yes ☐ No ☐
4. Is your child **currently taking any medications**/ what for?	
5. Has your child ever been hospitalized / what for?	
6. Has your child ever had difficulty with general anesthesia / describe?	

Your child's last dental visit:	Name of previous dentist :	Phone #:
What was your child treated for (i.e., cleaning, x-rays, fillings, etc.)?		
Has your child had previous dental x-rays / with who?	Date of last dental x-rays:	
Oral habits that your child may have? (i.e., thumb sucking, pacifiers, nursing, bottle, etc.)		
Any injuries to your child's mouth, teeth or head?		
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 #:	
Your child's 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. Sadler and the 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.

Signature of Parent or Guardian **Date**

Dr. Stephen Sadler requests that a parent/guardian remain in office while your child is being treated unless arraignments have been made with front desk!

Thank you!