overlake orthodontics

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete **both** sides of this form.

ADULT PATIENT INFORMATION

Patient's Name: ______________________________ Preferred Name: ______________ Birthdate: ___/___/___ Age: _____
First M.I. Last

Home Phone: (___) ____-_____ Home Address: ______________________ City/State: ______________ Zip: _______

Work Phone: (___) ____-_____ Employer: ____________________ How Long? _____ Occupation ______________

Cell Phone: (___) ____-_____ Employer's Address: ________________________ Soc. Sec. #: ___-__-____

E-Mail: ____________________ Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name: ______________________________ Birthdate: ___/___/___ Work Phone: (___) ____-_____

Employer/Occupation: ____ Soc. Sec. #: ___-__-____

Person Responsible for Account (if other than self or spouse): ______________________________

Who referred you, or how did you find out about our office? ______________________________

Do you know a patient currently in our practice? If so, who? ______________________________

List all other family members who have received treatment in our office ______________________________

We will gladly assist you in submitting insurance claims. A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or the person responsible for the account is responsible for payments of all fees incurred.

Insured Name: ______________________________ Soc. Sec. #: ___ - __ - ____ Birthdate: ___/___/___

Insurance Company: ____________________ Group Policy #: ____________ Ins. Co. Phone: (___) ____-_____

Insurance Company Address: ______________________________ Employer: ____________________

I release any information related to this claim and authorize payment of insurance benefits directly to Overlake Orthodontics.
I authorize this dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Signature ______________________________ Date ___/___/___

Please complete the back side of this form.

FOR OFFICE USE ONLY:

Benefit Amount $ ______________ Benefit Used ______________ Deductible? ___________ Age Limit? ______

Method of Payment: ❑ Monthly ❑ Quarterly ❑ Annual ❑ Other ______________ Continuation Form? ❑ Yes ❑ No

Confirmed On: ___/___/___ By: ______ ______________________________

Steven A. Lemery, DDS, MSD

Specialist in Orthodontics
for Children and Adults

website: www.overlakeorthodontics.com
email: info@overlakeorthodontics.com

p - 425.641.4200
f - 425.641.4418

Bel-Red Dental Center
14420 Bel-Red Road, Suite 105
Bellevue WA 98007-3930

DENTAL HISTORY

Dentist's Name:______________________ City:______________________ Phone: (____) _____-______

Dental Specialist Name:______________________ City:______________________ Phone: (____) _____-______

What are the main concerns that you would like orthodontics to accomplish?______________________

____

____

Who first noticed the orthodontic problem? ❑ Patient ❑ Dentist ❑ Other ______________________

What are the chief concerns you have related to the position of your teeth or bite:

- ❑ Appearance / Smile
- ❑ Comfort / Bite
- ❑ Stability / Shifting
- ❑ Jaw Joint / Muscle Discomfort
- ❑ Difficulty Cleaning / Gum Problem
- ❑ Ability to Chew / Function
- ❑ Wear / Fractures of Teeth
- ❑ Alignment of teeth prior to restoration of dental work (crowns, implants, etc.)

Question	No	Yes	
Have you had any injury to the face, mouth, chin or teeth?	❑ No	❑ Yes	Explain: ______________
Are you apprehensive about dental treatment?	❑ No	❑ Yes	Prior unpleasant experience? ______
Have you consulted an orthodontist previously?	❑ No	❑ Yes	With whom? ______________
Have you had any previous orthodontic treatment?	❑ No	❑ Yes	Satisfied?______________
Have permanent teeth been removed?	❑ No	❑ Yes	Explain: ______________
Have you noticed any recent changes in your bite or dental alignment?	❑ No	❑ Yes	Explain: ______________
Do you have any speech problems or tongue thrust?	❑ No	❑ Yes	Explain: ______________
Do you clench or grind your teeth during the day or night?	❑ No	❑ Yes	Aware of tooth wear? __________
Have you experienced jaw joint (TMJ) soreness, popping, or difficulty opening?	❑ No	❑ Yes	Explain:______________
Do you generally breathe through your mouth?	❑ No	❑ Yes	While awake? ______________

Is there any other information that may be helpful?______________________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY

Question	No	Yes	
Are you currently under physician's care?	❑ No	❑ Yes	Explain:______________
Are you currently taking medications?	❑ No	❑ Yes	List: ______________
Do you take medication (biophosphates) for osteoporosis?	❑ No	❑ Yes	List: ______________
Do you have allergies or drug sensitivities? Latex?	❑ No	❑ Yes	List: ______________
Do you need pre-medication before dental work?	❑ No	❑ Yes	Explain:______________

CHECK **ONLY IF** YOU HAVE BEEN **TREATED** FOR:

- ❑ Anemia or prolonged bleeding
- ❑ Asthma or hay fever
- ❑ Bone disorder/Osteoporosis
- ❑ Cancer
- ❑ Chronic sinus problems
- ❑ Diabetes
- ❑ Emotional problems
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Frequent or severe headaches
- ❑ Heart disease or murmur
- ❑ Hepatitis or liver disease
- ❑ Herpes (fever blisters)
- ❑ HIV positive (AIDS)
- ❑ Kidney disease
- ❑ Nervous disorders
- ❑ Rheumatic fever
- ❑ Venereal disease

Any other conditions you think we should know about? ______________________

Signature______________________ Date _____/_____/_____

Thank you for taking the time to complete this form.

Steven A. Lemery, DDS, MSD

Specialist in Orthodontics
for Children and Adults

website: www.overlakeorthodontics.com
email: info@overlakeorthodontics.com

p - 425.641.4200
f - 425.641.4418

Bel-Red Dental Center
14420 Bel-Red Road, Suite 105
Bellevue WA 98007-3930