overlake orthodontics

WELCOME TO OUR OFFICE

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

CHILD PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____ ❑ Female ❑ Male
First M.I. Last

Home Address: _____ City: _____ Zip: _____

Home Phone: (___) ___ - ____ Age _____ Birthdate ___/___/___ School _____ Grade _____

E-mail: _____ Patient Interest/Hobbies/Sports: _____

Who referred you and 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: _____

Parent or Guardian's Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Patient resides with: ❑ Both parents ❑ Mother ❑ Father Person(s) responsible for Account: _____

	Father	Mother	Step Parent/Guardian
Name:			
Address (if different from above):			
Cell Phone:	(__ __ __) - __ __ __ - __ __ __ __	(__ __ __) - __ __ __ - __ __ __ __	(__ __ __) - __ __ __ - __ __ __ __
Social Security Number:	__ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __
Employer/Occupation:			
Business Phone:	(__ __ __) - __ __ __ - __ __ __ __	(__ __ __) - __ __ __ - __ __ __ __	(__ __ __) - __ __ __ - __ __ __ __

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 parent or guardian who accompanies the child 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 the dental staff to perform any necessary dental services that my child 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

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

Child's Dentist: _____ _____ Approximate date of last check up: _____ _____
(City) (mo) (yr)

Patient's/Parent's chief concerns: _____

Are there any concerns about having orthodontic treatment? ❑ Discomfort ❑ Appearance of braces ❑ Length of treatment ❑ Other _____

DENTAL HISTORY

Have there been any injuries to the face, mouth, chin or teeth?	❑ No	❑ Yes	Explain: _____
Has your child had any baby or permanent teeth removed?	❑ No	❑ Yes	Explain: _____
Have you been informed of any missing or extra permanent teeth?	❑ No	❑ Yes	Explain: _____
Has your child ever seen an orthodontist before?	❑ No	❑ Yes	Explain: _____
Has your child had previous orthodontic treatment?	❑ No	❑ Yes	Satisfied: _____
Is your child concerned or worried about having orthodontic treatment?	❑ No	❑ Yes	Explain: _____
Is your child concerned about the appearance of his/her teeth?	❑ No	❑ Yes	Explain: _____
Does your child have difficulty chewing or swallowing food?	❑ No	❑ Yes	Explain: _____
Does your child have any speech problems or tongue thrust?	❑ No	❑ Yes	Explain: _____
Does your child grind or clench the teeth while sleeping?	❑ No	❑ Yes	Explain: _____
Has your child ever sucked a thumb or finger? If yes, until what age?	❑ No	❑ Yes	At this time? _____
Does your child frequently breathe through the mouth while sleeping?	❑ No	❑ Yes	While awake? _____
Does your child have any clicking, popping or soreness of the jaw joint?	❑ No	❑ Yes	Explain: _____
TO DETERMINE YOUR CHILD'S GROWTH POTENTIAL:			
Has your son or daughter reached puberty?	❑ No	❑ Yes	Explain: _____
Girls – Has she started menstruation?	❑ No	❑ Yes	What age? _____
Boys – Has his voice changed?	❑ No	❑ Yes	What age? _____
Child's height _____ Do you feel growth has been completed?	❑ No	❑ Yes	What age? _____
Father's height _____ Mother's height _____ Is your child adopted?	❑ No	❑ Yes	Explain: _____
Are your child's orthodontic problems similar to his/her parents?	❑ No	❑ Yes	Explain: _____
Have any siblings had orthodontic treatment?	❑ No	❑ Yes	With whom? _____

Patient's brothers and sisters: _____ _____ _____ _____ _____ _____
(Name) (Age) (Name) (Age) (Name) (Age)

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

MEDICAL HISTORY

Does your child have any allergies to medications or drugs? Or latex?	❑ No	❑ Yes	Explain: _____
Have tonsils and adenoids been removed?	❑ No	❑ Yes	What age? _____
Any drugs or medications now being taken?	❑ No	❑ Yes	Please list: _____
Does your child require pre-medication with antibiotics for dental work?	❑ No	❑ Yes	Explain: _____

CHECK ONLY IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING PROBLEMS:

❑ Anemia/abnormal bleeding	❑ Emotional problems	❑ Herpes (fever blisters)
❑ Asthma or hay fever	❑ Epilepsy	❑ HIV positive (AIDS)
❑ Bone or developmental disorder	❑ Fainting or dizziness	❑ Kidney disease
❑ Cancer	❑ Frequent or severe headaches	❑ Learning/Behavioral problems (e.g. ADD)
❑ Chronic sinus problems/ear infections	❑ Heart disease or murmur	❑ Prolonged bleeding
❑ Diabetes	❑ Hepatitis or liver disease	❑ Rheumatic fever

Any other conditions you think we should know about? _____

Signature _____ Date ____/____/____

Thank you for taking the time to complete this form.

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