

WELCOME!



lake hills orthodontics
wisanu charoenkul, dds ms

*So that we might become better acquainted,
Please complete the following:*

15446 Bel-Red Rd. Ste. 310

Redmond, WA 98052

Tel: (425)747-9210 Fax: (425)746-7486

Adult Patient Information

Patient's Name: _____ Today's Date: _____
Mailing Address: _____ City _____ State _____ Zip _____
Birth Date: ___/___/___ Age: ___ Male Female Grade _____ School _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ Name of Spouse (if married): _____
Employer: _____ Occupation: _____ Years Employed: _____
Dentist: _____ Date of Last Dental Check-Up _____
Whom may we thank for referring you to our office? _____

Responsible Party Information

Self Spouse Other Name: _____ Single Married Divorced Separated
Address: _____ City _____ State _____ Zip _____ Years _____
Home Phone: _____ Work Phone _____ Cell Phone _____
Social Security Number: ___-___-___ Birth Date _____ Relationship to Patient _____
Employer: _____ Occupation _____ Years Employed _____

Insurance Information

Policy Holder's Name: _____ Birth Date _____ SSN # _____
Insurance Company: _____ ID # _____ Group # _____
Insurance Co. Address: _____ City _____ State _____ Zip _____ Phone # _____
2nd Insured's Name: _____ Birth Date _____ SSN # _____
Insurance Company: _____ ID # _____ Group # _____
Insurance Co. Address: _____ City _____ State _____ Zip _____ Phone #: _____

I authorize and request my insurance company to pay directly to "Lake Hills Orthodontics – Wisanu Charoenkul, DDS MS" all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained and I agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. On occasion, Lake Hills Orthodontics will display photos of similar cases to prospective patients seeking outcomes of similar cases. I hereby give permission for use in the following instance. We will not use your photo in public displays without specific permission from you beforehand (i.e. Internet, Newspaper).

Signature _____

Relationship to Patient _____

Please turn over for more on the back...

Medical History Adult

Patient's Name: _____

Name of your physician: _____

Date of last exam _____

1. Are you in good health? Yes No
2. Do you have a health problem? Yes No If yes, please explain _____
3. Do you have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc.)?
 Yes No If yes, please list _____
4. Please list any current prescription medications you are taking: _____
5. Have you been treated by a physician for any of the following conditions? (Check any that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Delayed Growth	<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Anemia
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Kidney or Liver Involvement	<input type="checkbox"/> Epilepsy (convulsions)	<input type="checkbox"/> Rheumatic Trouble	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Metal Allergies (i.e. nickel)	<input type="checkbox"/> Emotional Issues	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Tonsils/Adenoids Removed	<input type="checkbox"/> Joint Prosthesis	<input type="checkbox"/> Earaches
<input type="checkbox"/> Compromised Immune System	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Lupus
6. Are you a smoker? Yes No For how long? _____ @ _____ packs/day.
7. (Female) Do you take birth control pills? Yes No Are you pregnant? Yes No

Dental History

What is your chief concern(s)? _____

Are you interested in (please indicate all that apply)

Information Treatment now Clarification of previous or conflicting information

1. Have you had any injuries or operations to your face, mouth, or teeth? Yes No
2. Do you know of any missing or extra permanent teeth? Yes No
3. Has any previous orthodontic treatment been rendered? Yes No
4. Do you have any sleeping difficulties? Yes No
5. Do you suffer from any jaw joint problems such as pain, clicking or popping? Yes No
6. Do you grind or clench your teeth during the day or night? Yes No
7. Inability to open mouth wide or move jaw normally? Yes No
8. Teeth difficult to clean? Yes No
9. Awareness of any gum or bone problems around teeth? Yes No
10. Concerned about the appearance of your teeth? Yes No
11. Concerned about the appearance of your face and/or jaw structure? Yes No
12. Have you been told you have sleep apnea? Yes No
13. Do you snore? Yes No
14. Do you have a problem with sleepiness during the day? Yes No
15. Do you tend to breathe through your mouth during the day? Yes No

What types of braces are you interested in? Metal Ceramic Clear Aligners I didn't know there were choices

Your attitude toward orthodontic treatment: Very Motivated Will Cooperate if needed Not Motivated

Comments: _____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services. I give permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, or for publication in professional journals.

Signature _____

Relationship to Patient _____