

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

Child Patient Information

Patient's Name: _____ Today's Date: _____
Mailing Address: _____ City _____ State _____ Zip _____
Birth Date: ___/___/___ Age: ___ Male Female Grade _____ School _____
Dentist: _____ Date of Last Dental Check-Up _____
Whom may we thank for referring you to our office? _____

Responsible Party Information

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

Name: _____ Relationship to Patient: _____ Single Married Divorced Separated
Address: _____ City _____ State _____ Zip _____ Years _____
Home Phone: _____ Work Phone _____ Cell Phone _____
Social Security Number: ___-___-___ Birth Date _____ Email _____
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 **Child**

Patient's Name: _____

Name of your physician: _____

Date of last exam _____

1. Is the patient in good health? Yes No
2. Does the patient have a health problem? Yes No If yes, please explain _____
3. Does the patient 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: _____
5. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)
 Diabetes Delayed Growth Bone Disorders Anemia
 Mitral Valve Prolapse Prolonged Bleeding Fainting/Dizziness Heart Trouble
 Kidney or Liver Involvement Epilepsy (convulsions) Rheumatic Trouble Thyroid Problems
 Learning Disabilities Metal Allergies (i.e. nickel) Emotional Issues Arthritis
 Frequent Sore Throats Tonsils/Adenoids Removed Joint Prosthesis Earaches
 Compromised Immune System Rheumatoid Arthritis Joint Swelling Lupus
6. Does the patient smoke? Yes No For how long? _____ @ _____ packs/day.
7. Does the patient take birth control pills? Yes No Is the patient 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 there been injuries or operations to the 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. Does the patient have any speech problems? Yes No
 5. Does the patient suffer from any jaw joint problems such as pain, clicking or popping? Yes No
 6. Have you ever observed your child has any habits? Thumb/finger sucking Mouth breathing Tongue thrust
 7. While sleeping, does your child snore loudly? Yes No
 8. Does your child tend to breathe through the mouth during the day? Yes No
 9. Does your child have a problem with sleepiness during the day? Yes No
 10. Has your child been diagnosed with ADHD? Yes No

Jaw Growth

In some instances, the ability of Dr. Charoenkul to help guide the growth amount and direction of your child's jaw may be critical to the success of the orthodontic treatment plan. In order to determine your child's jaw growth potential, please answer the following:

Do you feel he/she is still growing?

Yes No

GIRLS: Has she started menstruation (monthly periods)? Yes No

Approximately when did menstruation begin? _____

Patient's current height: _____

BOYS: Has his voice changed: Yes No Started to shave? Yes No

Mother's ht: _____ Father's ht: _____

Approximately when did these changes begin? _____

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

Patient's attitude toward orthodontic treatment: Very Motivated Will Cooperate if needed Not Motivated

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 _____