WELCOME!

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

lake hills orthodontics
wisanu charoenkul, dds ms

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 _____

Insurance Subscribers 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 _____

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

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

Patient's current height: _____

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

GIRLS: Has she started menstruation (monthly periods)? □ Yes □ No
Approximately when did menstruation begin? _____

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