WELCOME!

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

redmond orthodontics
Danilee K. Baldwin, DDS, MSD, PS
7530 164th Ave. NE, #A250
Redmond, WA 98052
Tel: (425) 861-9685

Adult Patient Information

Patient's Name _____ Today's Date _____

Birth Date____/_____/_____ Age_____ ❑M ❑F

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone_____

Email _____ Preferred Contact Method: Home # / Work # / Cell # / Email

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 _____ Yrs ____

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 _____

Emergency Information

Name of nearest relative *not* living with you _____Phone_____

Please turn over for more on the back...

Medical History

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, 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 current prescription medications you are taking: _____
5. Have you ever taken or are taking bisphosphonates for osteoporosis?_____
6. (Women) Are you pregnant? ❑Yes ❑No
7. Have you been treated by a physician for any of the following conditions? (Check any that apply)

- ❑ Problems at Birth
- ❑ Heart Disease/Murmur
- ❑ Rheumatic Fever
- ❑ Sickle Cell Anemia
- ❑ Anemia/Hemophilia
- ❑ Diabetes
- ❑ AIDS or HIV
- ❑ Hepatitis/Liver Disease
- ❑ Tuberculosis
- ❑ Kidney Disease
- ❑ Cancer/Radiation Therapy
- ❑ Cerebral Palsy
- ❑ Arthritis
- ❑ Asthma
- ❑ Seizures
- ❑ Cleft Lip/Palate
- ❑ Speech or Hearing Problems
- ❑ Tonsil, Adenoid, Sinus Problems
- ❑ Emotional/Behavior Problems
- ❑ Learning Disabilities
- ❑ Growth Problems

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

Check any of the following that apply and explain below:

1. ❑ Any injuries or operations to the face, mouth, or teeth?
2. ❑ Do you know of any missing or extra permanent teeth?
3. ❑ Has any previous orthodontic treatment been rendered?
4. ❑ Do you have any speech difficulty?
5. ❑ Do you suffer from any jaw joint problems such as pain, clicking or popping?
6. ❑ Do you grind or clench your teeth during the day or night?
7. ❑ Inability to open mouth wide or move jaw normally?
8. ❑ Have you ever sucked your thumb or fingers? Until what age?
9. ❑ Teeth difficult to clean?
10. ❑ Awareness of any gum or bone problem around teeth?
11. ❑ Concerned about the appearance of your teeth?
12. ❑ Concerned about the appearance of your face and/or jaw structure?

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. This office reserves the right to verify the credit status of potential patient and/or parents of patients prior to extending credit for treatment fees.

Signature_____**Relationship to Patient**_____

Updates (date and initial)_____