

# WELCOME!



## redmond orthodontics

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

### Child Patient Information

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  M  F Grade \_\_\_\_\_ School \_\_\_\_\_  
Dentist \_\_\_\_\_ Date of Last Dental Check Up \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

### Responsible Party Information

Father's Name \_\_\_\_\_  Single  Married  Divorced  Separated  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Yrs \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Mother's Name \_\_\_\_\_  Single  Married  Divorced  Separated  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Yrs \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Preferred Contact Method: Mom's: Home # / Work # / Cell # / Email Dad's: Home # / Work # / Cell # / Email

### Insurance Information

Policy Holder's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Insurance Company \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

2<sup>nd</sup> 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. Is the patient in good health?  Yes  No
2. Does the patient have a health problem?  Yes  No If yes, 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)

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

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. Baldwin 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? \_\_\_\_\_

*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) \_\_\_\_\_