

Child's Dentist: _____ (City) _____ Approximate date of last check up: _____ (mo) _____ (yr)

Patient's/Parent's chief concerns: _____

Are there any concerns about having orthodontic treatment? Discomfort Appearance of braces Length of treatment Other _____

DENTAL HISTORY

Have there been any injuries to the face, mouth, chin or teeth? No Yes Explain: _____

Has your child had any baby or permanent teeth removed? No Yes Explain: _____

Have you been informed of any missing or extra permanent teeth? No Yes Explain: _____

Has your child ever seen an orthodontist before? No Yes Explain: _____

Has your child had previous orthodontic treatment? No Yes Satisfied: _____

Is your child concerned or worried about having orthodontic treatment? No Yes Explain: _____

Is your child concerned about the appearance of his/her teeth? No Yes Explain: _____

Does your child have difficulty chewing or swallowing food? No Yes Explain: _____

Does your child have any speech problems or tongue thrust? No Yes Explain: _____

Does your child grind or clench the teeth while sleeping? No Yes Explain: _____

Has your child ever sucked a thumb or finger? If yes, until what age? No Yes At this time? _____

Does your child frequently breathe through the mouth while sleeping? No Yes While awake? _____

Does your child have any clicking, popping or soreness of the jaw joint? No Yes Explain: _____

TO DETERMINE YOUR CHILD'S GROWTH POTENTIAL:

Has your son or daughter reached puberty? No Yes Explain: _____

Girls – Has she started menstruation? No Yes What age? _____

Boys – Has his voice changed? No Yes What age? _____

Child's height _____ Do you feel growth has been completed? No Yes What age? _____

Father's height _____ Mother's height _____ Is your child adopted? No Yes Explain: _____

Are your child's orthodontic problems similar to his/her parents? No Yes Explain: _____

Have any siblings had orthodontic treatment? No Yes With whom? _____

Patient's brothers and sisters: _____ (Name) _____ (Age) _____ (Name) _____ (Age) _____ (Name) _____ (Age)

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY

Does your child have any allergies to medications or drugs? Or latex? No Yes Explain: _____

Have tonsils and adenoids been removed? No Yes What age? _____

Any drugs or medications now being taken? No Yes Please list: _____

Does your child require pre-medication with antibiotics for dental work? No Yes Explain: _____

CHECK ONLY IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING PROBLEMS:

<input type="checkbox"/> Anemia/abnormal bleeding	<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Herpes (fever blisters)
<input type="checkbox"/> Asthma or hay fever	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV positive (AIDS)
<input type="checkbox"/> Bone or developmental disorder	<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent or severe headaches	<input type="checkbox"/> Learning/Behavioral problems (e.g. ADD)
<input type="checkbox"/> Chronic sinus problems/ear infections	<input type="checkbox"/> Heart disease or murmur	<input type="checkbox"/> Prolonged bleeding
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis or liver disease	<input type="checkbox"/> Rheumatic fever

Any other conditions you think we should know about? _____

Signature _____ Date _____/_____/_____

Samuel L. Lake, DDS, MSD, PS

Thank you for filling out this form completely.

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