overlake orthodontics

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete **both** sides of this form.

ADULT PATIENT INFORMATION

Patient's Name: _____ (First M.I. Last) Preferred Name: _____ Birthdate: ___/___/___ Age: _____

Home Phone: (___) ___-____ Home Address: _____ City/State: _____ Zip: _____

Work Phone: (___) ___-____ Employer: _____ How Long? _____ Occupation _____

Cell Phone: (___) ___-____ Employer's Address: _____ Soc. Sec. #: ___-___-____

E-Mail: _____ Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name: _____ Birthdate: ___/___/___ Work Phone: (___) ___-____

Employer/Occupation: _____ Soc. Sec. #: ___-___-____

Person Responsible for Account (if other than self or spouse): _____

Who referred you, or how did you find out about our office? _____

Do you know a patient currently in our practice? If so, who? _____

List all other family members who have received treatment in our office _____

We will gladly assist you in submitting insurance claims. A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or the person responsible for the account is responsible for payments of all fees incurred.

Insured Name: _____ Soc. Sec. #: ___-___-____ Birthdate: ___/___/___

Insurance Company: _____ Group Policy #: _____ Ins. Co. Phone: (___) ___-____

Insurance Company Address: _____ Employer: _____

I release any information related to this claim and authorize payment of insurance benefits directly to Overlake Orthodontics.
I authorize this dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Signature _____ Date ___/___/___

Please complete the back side of this form.

FOR OFFICE USE ONLY:

Benefit Amount $_____ Benefit Used _____ Deductible? _____ Age Limit? _____

Method of Payment: ❑ Monthly ❑ Quarterly ❑ Annual ❑ Other _____ Continuation Form? ❑ Yes ❑ No

Confirmed On: ___/___/___ By: _____ _____

Steven A. Lemery, DDS, MSD

Specialist in Orthodontics
for Children and Adults

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Bel-Red Dental Center
14420 Bel-Red Road, Suite 105
Bellevue WA 98007-3930

DENTAL HISTORY

Dentist's Name: _____ City: _____ Phone: (___) ___-____

Dental Specialist Name: _____ City: _____ Phone: (___) ___-____

What are the main concerns that you would like orthodontics to accomplish? _____

_____

_____

Who first noticed the orthodontic problem? ❑ Patient ❑ Dentist ❑ Other _____

What are the chief concerns you have related to the position of your teeth or bite:

❑ Appearance / Smile
❑ Comfort / Bite
❑ Stability / Shifting
❑ Jaw Joint / Muscle Discomfort
❑ Difficulty Cleaning / Gum Problem
❑ Ability to Chew / Function
❑ Wear / Fractures of Teeth
❑ Alignment of teeth prior to restoration of dental work (crowns, implants, etc.)

Have you had any injury to the face, mouth, chin or teeth?	❑ No	❑ Yes	Explain: _____
Are you apprehensive about dental treatment?	❑ No	❑ Yes	Prior unpleasant experience? _____
Have you consulted an orthodontist previously?	❑ No	❑ Yes	With whom? _____
Have you had any previous orthodontic treatment?	❑ No	❑ Yes	Satisfied? _____
Have permanent teeth been removed?	❑ No	❑ Yes	Explain: _____
Have you noticed any recent changes in your bite or dental alignment?	❑ No	❑ Yes	Explain: _____
Do you have any speech problems or tongue thrust?	❑ No	❑ Yes	Explain: _____
Do you clench or grind your teeth during the day or night?	❑ No	❑ Yes	Aware of tooth wear? _____
Have you experienced jaw joint (TMJ) soreness, popping, or difficulty opening?	❑ No	❑ Yes	Explain: _____
Do you generally breathe through your mouth?	❑ No	❑ Yes	While awake? _____

Is there any other information that may be helpful? _____

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

MEDICAL HISTORY

Are you currently under physician's care?	❑ No	❑ Yes	Explain: _____
Are you currently taking medications?	❑ No	❑ Yes	List: _____
Do you take medication (biophosphates) for osteoporosis?	❑ No	❑ Yes	List: _____
Do you have allergies or drug sensitivities? Latex?	❑ No	❑ Yes	List: _____
Do you need pre-medication before dental work?	❑ No	❑ Yes	Explain: _____

CHECK **ONLY IF** YOU HAVE BEEN **TREATED** FOR:

❑ Anemia or prolonged bleeding
❑ Asthma or hay fever
❑ Bone disorder/Osteoporosis
❑ Cancer
❑ Chronic sinus problems
❑ Diabetes
❑ Emotional problems
❑ Epilepsy
❑ Fainting or dizziness
❑ Frequent or severe headaches
❑ Heart disease or murmur
❑ Hepatitis or liver disease
❑ Herpes (fever blisters)
❑ HIV positive (AIDS)
❑ Kidney disease
❑ Nervous disorders
❑ Rheumatic fever
❑ Venereal disease

Any other conditions you think we should know about? _____

Signature _____ Date ____/____/____

Thank you for taking the time to complete this form.

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