WELCOME!

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

Danilee K. Baldwin, DDS, MSD, PS
16150 NE 85th St., Suite #212
Redmond, WA 98052
Tel: (425) 861-7900 Fax: (425) 867-1026

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 _____________________________________ Group No. _______________ Local No. _____________

Insurance Co Address _________________________________ City ______________________ State ______ Zip _________

Phone _______________________________

2nd Insured's Name __________________________________ Birth Date _____/_____/_____ SSN ______ - _____ - _______

Insurance Company _____________________________________ Group No. _______________ Local No. _____________

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)

❑ 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

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: __________
Mother's Ht:_____ Father's Ht:______

BOYS: Has his voice changed? ❑ Yes ❑ No Started to shave? ❑ Yes ❑ No
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)____