

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 _____
Family Email Address : _____
Social Security Number ___ - ___ - ___ Birth Date ___/___/___ Relationship to Patient _____
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 ___/___/___ Relationship to Patient _____
Employer _____ Occupation _____ Years Employed _____

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)

<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

Patient's current height: _____

Mother's Height: _____

GIRLS: Has she started menstruation (monthly periods)? Yes No

Approximately when did menstruation begin? _____

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) _____