SURBECK ORTHODONTICS
375 118th Ave SE ,Suite 100, Bellevue, WA 98005 425-455-1944

WELCOME TO OUR OFFICE

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

CHILD PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____ ❒Female ❒ Male
First M.I. Last

Home Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Age: _____ Birth date: ____/____/____ School: _____

Email: _____ Patient Interest/Hobbies/Sports: _____

Who referred you and/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 orthodontic treatment in our office: _____

Parent or Guardian's Marital Status: ❒Single ❒Married ❒Separated ❒Divorced ❒ Widowed

Patient resides with: ❒ Both Parents ❒ Mother ❒ Father Person(s) responsible for account _____

	Father	Mother	Step-parent/Guardian
Name:			
Address: (if different than above)			
Cell Phone:	(____) _____ - _____	(____) _____ - _____	(____) _____ - _____
Employer/Occupation:			
Work Phone:	(____) _____ - _____	(____) _____ - _____	(____) _____ - _____

Sister(s) Name(s): _____ Brother(s) Name(s): _____

We will gladly assist you in submitting your insurance claims. Release of benefits and information: I authorize my insurance benefits to be paid directly to Dr. Burleigh Surbeck and that I am financially responsible for any balance due. I authorize Dr. Surbeck or the insurance company to release any information required for this claim. I recognize that the New Patient Child Exam fee is $30, which I will pay should my insurance not cover the exam.

Policy Holder's Name: _____ ID/SS # _____ Birth date: _____/_____/_____

Insurance Company: _____ Group # _____ Phone # _____

Employer: _____

Policy Holder's Name: _____ ID/SS # _____ Birth date: _____/_____/_____

Insurance Company: _____ Group # _____ Phone # _____

Employer: _____

Signature: _____ Date: _____

Please complete the backside of this form.

FOR OFFICE USE ONLY:							
Benefit Amount $		Benefit Used $		Deductable:$		Age Limit:	
Method of Payment	❒ Monthly	❒ Quarterly	❒ Annual	❒ Other	Continuation Form	❒ YES	❒ NO
Confirmed on:	/ /	By:					

Patient's Dentist: _____ _____ Approximate date of last check-up _____ _____ Any X-Rays?_____
(city) (mo) (yr)

Has your child had any previous orthodontic treatment? ❒NO ❒YES If yes, with whom? _____
If yes, satisfied? _____

Has your child consulted an orthodontist previously? ❒NO ❒YES If yes, with whom? _____

Patient's/Parents' primary concerns: _____

Has any other immediate family members received orthodontic treatment? ❒NO ❒YES If yes, with whom and satisfied? _____

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

DENTAL HISTORY

Does your child have a fear of dental treatment?	❒NO	❒YES	Explain:
Has your child had an unpleasant experience in a dental office?	❒NO	❒YES	Explain:
Is there any unfinished care to be completed by your child's dentist?	❒NO	❒YES	Explain:
Has 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:
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	If yes, what sounds?
Does your child grind or clench their teeth while sleeping or awake?	❒NO	❒YES	❒AWAKE ❒ASLEEP
Has your child ever sucked a thumb or finger?	❒NO	❒YES	If yes, until what age?_____ Currently?
Does your child frequently breathe through their mouth?	❒NO	❒YES	❒AWAKE ❒ASLEEP
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	Explain:
Boys– Has his voice changed?	❒NO	❒YES	Explain:
Child's height _____ Do you feel growth has completed?	❒NO	❒YES	Explain:
Father's Height_____ Mother's Height_____			
Is your child adopted	❒NO	❒YES	Explain:

MEDICAL HISTORY

Does your child have any allergies? **(ex: medications, foods, latex, bees)**	❒NO	❒YES	Explain:
Is your child currently taking any medication?	❒NO	❒YES	Explain:
Has your child experienced any health problems?	❒NO	❒YES	Explain:
Any major changes in your child's health recently?	❒NO	❒YES	Explain:
Is your child currently under physician's care?	❒NO	❒YES	Explain:
Have your child's tonsils or adenoids been removed?	❒NO	❒YES	Explain:
Has your child ever received a blood transfusion?	❒NO	❒YES	Explain:
Has your child been in a risk group for aids?	❒NO	❒YES	Explain:

Please check *ONLY* if your child has had any of the following conditions:

❒ Heart Murmur	❒ Hepatitis A (infectious)	❒ Emotional problems
❒ Heart Surgery	❒ Hepatitis B	❒ Frequent Headaches
❒ Artificial Valves/Stents	❒ Hepatitis C	❒ Nervous/ Anxious
❒ Rheumatic fever	❒ Diabetes	❒ Shortness of Breath
❒ Endocrine Disorder	❒ Kidney Disease	❒ Cancer
❒ Prolonged Bleeding	❒ Liver Disease	❒ Bone Disorder
❒ Anemia	❒ Tuberculosis	❒ Growth Disorder
❒ Blood Disease	❒ Bronchitis	❒ Herpes (Fever Blisters)
❒ Development Disorder	❒ Asthma	❒ Tonsillitis
❒ Hives/Rash	❒ Epilepsy	❒ HIV Positive (AIDS)
❒ Artificial Joints	❒ Fainting	

Is there any other condition that you think we should know about? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

Signature _____ Date ___/___/___