

Randolph L. Lake, DDS

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: (_____) _____ Birthdate ____ / ____ / ____ School _____

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

List all other family members who have received 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 from above):	_____	_____	_____
Phone (if different from above): Hm _____			
Wrk _____			
Cell _____			
Social Security Number:	_____	_____	_____
Employer/Occupation:	_____	_____	_____

Prior Dentist's Name: _____ Approx. date of last visit? _____

Why did you leave? _____

*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: _____

Do you have dual coverage? If yes, complete the following:

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 Randolph L. Lake, DDS. I authorize this dental staff to perform any necessary dental services that I may need during diagnosis and treatment. All unpaid balances are subject to a 1.5% per month service charge 60 days after billing. Payment in full or insurance co-payment is due at the time of service.

Signature _____ Date ____ / ____ / ____

Please complete the back side of this form.

Randolph L. Lake, DDS
Family & Cosmetic Dentistry

3200 NE Sunset Blvd. • Renton, WA 98056 • Phone: (425) 228-2555 • Fax: (425) 228-0220

Health History

Please complete the following information.

Dental History

Why have you brought your child to the dentist today? _____

Is your child currently experiencing dental pain? No Yes Explain: _____

Has your child ever had a serious or difficult experience with previous dental treatment? No Yes Explain: _____

Is your child apprehensive about dental treatment? No Yes Explain: _____

Is there anything you would like to change about your child's smile?

- Color of teeth Straighten crooked teeth Replace missing teeth
 Replace chipped or broken teeth Other _____

Medical History

Does your child have or has ever had any of the following:

- | | | |
|--------------------------|------------------------------|-----------------------------|
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Heart Condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Has your child had an adverse reaction or allergy to any of the following:

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Latex | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ibuprofen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penicillin or Other Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dental Anesthetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nickel | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other Medications: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If yes, please list: _____

What medications is your child currently taking? _____

Other physical conditions we should know about? _____

Physician's Name _____ Phone: (_____) _____

If necessary may we request your child's medical records? Yes No