Lakes Orthodontics
Estee Wang, DMD MS

Hi,

Thank you for selecting Lakes Orthodontics for your orthodontic treatment needs!

Our team is excited to meet you at your orthodontic consultation appointment. During your visit, we will do a comprehensive orthodontic exam including any necessary orthodontic records. If treatment is recommended, we will discuss the treatment plan, estimated time for treatment, and the fees associated with this service. If you have insurance that covers orthodontic treatment, please provide that information before the day of your consultation so that we can give you an estimated benefit during your appointment.

We have included some important forms with this letter. Please complete them ahead of time and bring them with you to your appointment. We are looking forward to a relaxed and pleasant visit with you. Please call or visit our website at www.lakesorthodonticsmn.com for directions or for more information about our practice. We look forward to meeting you!

Sincerely yours,

Dr. Wang and Staff at Lakes Orthodontics

Lakes Orthodontics
Dr. Estee Wang, DMD MS
1668 Cope Ave. East ◦ Maplewood, MN 55109
651.777.7300 ◦ www.lakesorthodonticsmn.com

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PATIENT INFORMATION - YOUTH

Date _____

Patient's Legal Name _____ Preferred Name _____

DOB _____ Gender _____ School/Grade _____

Hobbies/Interests _____

Person Present with Patient at Exam _____ Relationship to Patient _____

How did you hear about our practice? _____ General Dentist _____

Past or Present Family Members in Treatment _____

Have you Consulted an Orthodontist Before? _____

PARENT/GUARDIAN INFORMATION

Mother's Name _____ DOB _____

E-Mail Address _____ Marital Status/Spouse's Name _____

Address (Street)_____ (City/State) _____ (Zip)_____

Phone (Home/Cell) _____ Employer/Occupation _____

Father's Name _____ DOB _____

E-Mail Address _____ Marital Status/Spouse's Name _____

Address (Street)_____ (City/State) _____ (Zip)_____

Phone (Home/Cell) _____ Employer/Occupation _____

INSURANCE INFORMATION

Subscriber's Name _____ DOB _____

Address _____ Phone _____

Employer _____

Insurance Company _____ Phone _____

Group Number _____ Subscriber ID/SS# _____

Signature _____ Date _____
(Parent/Legal Guardian)

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MEDICAL HISTORY

Patient's Name _____ Date _____

Dentist's Name _____ Date of Last Dental Exam _____

Physician's Name _____ Date of Last Physical Exam _____

Allergies or reactions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotics
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other _____

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past, has the patient had:

Y __ N __ Adenoids or tonsils removed
Y __ N __ Arteriosclerosis (hardening of the arteries)
Y __ N __ Asthma, hay fever, sinus trouble or hives
Y __ N __ Autoimmune disorders or immune system problems
Y __ N __ Bleeding or bruising easily
Y __ N __ High or low blood pressure – please circle
Y __ N __ Cancer, tumor, chemotherapy or radiation treatment
Y __ N __ Chronic fatigue
Y __ N __ Current pregnancy
Y __ N __ Depression or other mental health disturbance
Y __ N __ Diabetes
Y __ N __ Dizziness
Y __ N __ Epilepsy or other seizure disorder
Y __ N __ Fibromyalgia
Y __ N __ General anesthesia
Y __ N __ Hearing impairment
Y __ N __ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y __ N __ Frequent coughs, colds or sore throats
Y __ N __ Hemophilia
Y __ N __ Hepatitis, AIDS or HIV positive
Y __ N __ Injury to face, neck, mouth or teeth – please circle
Y __ N __ Insomnia
Y __ N __ Jaw joint surgery
Y __ N __ Kidney or liver problems
Y __ N __ Meniere's disease
Y __ N __ Multiple sclerosis
Y __ N __ Muscular dystrophy
Y __ N __ Nighttime breathing problems (snoring or sleep apnea)
Y __ N __ Nervousness
Y __ N __ Neuralgia
Y __ N __ Osteoarthritis (stiff or swollen joints)
Y __ N __ Osteoporosis
Y __ N __ Parkinson's disease
Y __ N __ Prior orthodontic treatment
Y __ N __ Psychiatric care
Y __ N __ Rheumatic fever
Y __ N __ Rheumatoid arthritis
Y __ N __ Scarlet fever
Y __ N __ Skin disorder
Y __ N __ Speech difficulties
Y __ N __ Stroke or heart attack
Y __ N __ Tuberculosis
Y __ N __ Wisdom teeth extraction
Y __ N __ Birth defects or hereditary problems
Y __ N __ Endocrine or thyroid problems
Y __ N __ Stomach ulcer or hyperacidity
Y __ N __ Polio, mononucleosis or pneumonia
Y __ N __ Vision problems
Y __ N __ Loss of weight recently, poor appetite
Y __ N __ Eating disorder (anorexia or bulimia)
Y __ N __ Chest pain, shortness of breath or swelling ankles
Y __ N __ Frequent or severe headaches
Y __ N __ Other condition

Emergency Contact _____ Relationship _____ Phone # _____

Patient/Parent Signature _____ Today's Date _____

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