

John C. Ive, D.D.S., M.S.D.

Diplomate, American Board of Orthodontics

Practice Limited to Orthodontics

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DATE _____

PATIENT INFORMATION

Name _____ Birthdate _____ Age _____ Sex M F
Address _____ City _____ State _____ Zip _____
Phone _____ Cell Phone _____
School _____ School District _____
Siblings names and ages _____
Person to call in case of emergency _____ Phone _____ Relationship _____

RESPONSIBLE PARTY

Name of person responsible for account _____
Relationship to patient _____ Home Phone _____ Cell Phone _____
Email Address _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work phone _____
Marital status: ___ Single ___ Married ___ Divorced - Share financial responsibility with another person? ___ Y ___ N
If yes above, with whom _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Email Address _____

INSURANCE INFORMATION

Primary Dental Insurance _____
Insurance Co. Phone _____
Group # / Employer _____
Name of Subscriber _____
Soc. Sec. / ID # _____ Birthdate _____

Secondary Dental Insurance _____
Insurance Co. Phone _____
Group # / Employer _____
Name of Subscriber _____
Soc. Sec. / ID # _____ Birthdate _____

MEDICAL HISTORY

Does your child have?
Y N Heart Disease / defect / murmur
Y N Rheumatic Fever
Y N Diabetes
Y N Cancer or Tumor
Y N Hepatitis
Y N Epilepsy
Y N Asthma or Hay Fever
Y N Sinus Trouble
Y N Emotional / Behavioral Problems
Y N Kidney / Liver Disorder
Y N Prolonged Bleeding
Y N Anemia
Y N Slow in Learning
Y N Special Problems _____

MEDICAL INFORMATION

Is your child allergic to: Penicillin? Sulphur Drugs?
(circle) Codeine? Latex? Other? _____
For what purpose: _____
Is your child under the care of a physician? Y N
Date of last medical exam _____

Physician _____
Dentist _____
Referred by _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company(s) and assign directly to Dr. John C. Ive all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

