

Please fill out this form completely

Today's Date _____

Name _____ Likes to be called _____ Male Female

Home Address _____ Zip _____ SS# _____

Do you Own _____ Do you Rent _____ How long _____

Home Phone _____ Cell Phone _____ E-Mail address _____

Birth Date ____/____/____ Age _____

Hobbies/Sports _____

Musical instruments you play _____

Employer _____ Occupation _____ How long _____

Address _____ Work Phone _____ Extension _____

If Married: Spouse _____

Employer _____ Work Phone _____

If Single: Emergency Contact Name _____ Relationship _____

Home Phone _____ Work Phone _____

Dentist _____ Date of last visit _____

How did you hear about our office? Please check one. Dentist Individual: _____ Yellow Pages Location Webpage Internet Other _____

Family members seen by us _____

MEDICAL HISTORY

Physician _____ Phone _____ Date of last visit _____

Are you currently taking any medication? Yes No if yes, please explain _____

Please list any drug allergies _____

Do you chew or smoke tobacco? _____ If yes how long? _____ how much? _____ type? _____

Have you ever had or currently any of the following medical problems?

- Yes No Allergy to Plastic / Latex / Metals Yes No Drug / Alcohol Abuse
- Yes No Cancer/Tumor/Chemotherapy Yes No Convulsions / Epilepsies
- Yes No Diabetes Yes No Abnormal Bleeding
- Yes No Rheumatic Fever Yes No Hearing Impairment
- Yes No HIV / AIDS Yes No Any Operations
- Yes No Stomach, Intestinal Trouble Yes No Blood Transfusion
- Yes No Asthma / Emphysema Yes No Kidney / Liver Problems
- Yes No Hepatitis Liver Involvement Yes No Handicaps / Disabilities
- Yes No Tuberculosis Yes No Congenital Heart Defect or Heart Murmur
- Yes No Heart Attack / Stroke Yes No Heart Surgery / Pacemaker
- Yes No Shingles / Fever Blisters Yes No Bone Disorders / Swollen Painful Joints
- Yes No Artificial Valves or Joints Yes No Sinus Problems / Allergies
- Yes No High / Low Blood Pressure Yes No Ear, Nose, or Throat Problems
- Yes No Severe / Frequent Headaches Yes No Psychiatric Problems / Nervous Disorder
- Yes No Sexually Transmitted Disease Yes No Hemophilia / Prolonged Bleeding
- Yes No Ulcers / Colitis Yes No Anemia / Fainting or Dizziness
- Yes No Difficulty Breathing / Pneumonia Yes No Glaucoma / Eye Problems
- Yes No Any Stays in a Hospital (Please Explain) Yes No Pregnant, If yes # of weeks _____

Please discuss any medical problems that you have had.

DENTAL HISTORY ☺

Do you have any of the following habits? (Please check)

- Forcing jaw to pop Mouth Breathing Lip Sucking / Biting Speech Problems
- Clenching / Grinding Teeth Nail Biting Tongue Thrust

- Have you ever been evaluated for orthodontic treatment? Yes No
- Have there been any injuries to the Face Mouth Teeth Chin Are any teeth loose? Yes No
- Have you ever worn braces? Yes No
- Have you ever had a problem associated with previous dental work? Yes No
- Do you now or have you ever had pain/tenderness in your jaw joint (TMJ)? Yes No
- Your current dental health is Good Fair Poor
- How many times a day do you brush your teeth? _____ Do you floss daily? Yes No
- Regular visits to dentist? Yes No
- Have you had x-rays taken of all of your teeth in the past year? Yes No
- Do you have any missing or extra permanent teeth? Yes No
- Any pain when chewing or biting? Yes No Sores in or around mouth? Yes No
- Have you ever sucked a thumb or fingers? Yes No Until what age? _____
- Do you generally breathe through your mouth? Awake Yes No Asleep Yes No

What are your main orthodontic concerns?

- Overbite (upper teeth covering lower teeth) Buck Teeth (upper teeth protruding) Underbite (upper front teeth behind lower front teeth)
- Jaw Problems (popping noise or discomfort) Missing Teeth (never came in or lost teeth) Crooked Teeth (teeth crossing over each other)
- Crowding (not enough space between teeth) Other _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

The information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence, and **it is my responsibility to inform this office of any changes in my medical status.** I authorize the dental staff to perform any necessary dental services that may be need.

Signature _____ **Date** _____

Insurance Assignment:

I authorize Lisa King DDS MS and/or her staff to file and accept assignment of any insurance benefits that pertain to all orthodontic treatment. It is my responsibility to notify your office of any changes in coverage. This assignment will remain in effect unless revoked in writing. I will accept personal responsibility of amount left unpaid from expected benefits.

Signature: _____ Date: _____

*****FOR OFFICE USE ONLY*****

EXAM RESULTS: _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ Date _____

Estimate: \$ _____ to \$ _____ Next Appt. _____ Scheduled _____ @ _____