

Please fill out this form completely.

Today's Date _____

Name _____ Likes to be called _____ Male Female

Home Address _____ Zip _____

Home Phone _____ Child's Cell Phone _____ Child's Email _____

Birth Date ____/____/____ School _____ Grade _____

Hobbies/Sports _____ Family members seen by us _____

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

Location Webpage Internet Other _____

Who is accompanying the child today? _____ Relationship _____

Do you have legal custody of this child? Yes No If not, who does? _____

RESPONSIBLE PARTY INFORMATION

Married _____ Separated _____ Divorced _____ Single _____

Name _____ Parent Step Parent Guardian If Married: Spouse _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Occupation _____ How long _____ Work Phone _____

Do you own _____ rent _____ How long _____ E-Mail _____ Cell Phone _____

Second Home:

Name _____ Parent Step Parent Guardian If Married: Spouse _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Occupation _____ How Long _____ Work Phone _____

Cell Phone _____ E-Mail _____

MEDICAL HISTORY

Patient's Physician _____ Phone _____ Date of last visit _____

Is any Medication being taken at this time? Yes No If yes, please explain _____

Please list any drug allergies _____

Has puberty begun? _____ For Girls- date menstruation begun? _____ For Boys-date voice changed? _____

Fathers Height _____ Mothers Height _____ Patients teeth most resemble? Mom Dad

Does your child chew or smoke tobacco? _____ If yes, how long? _____ How much? _____ Type? _____

Has your child ever had 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 / Epilepsy
 Yes No Diabetes Yes No Abnormal Bleeding
 Yes No Rheumatic Fever Yes No Hearing Impairment
 Yes No HIV / AIDS Yes No Any Operations /Stays in the hospital
 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

- | | | | | | |
|------------------------------|-----------------------------|----------------------------------|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Severe / Frequent Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Problems / Nervous Disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia / Prolonged Bleeding |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers / Colitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia / Fainting or Dizziness |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Difficulty Breathing / Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma / Eye Problems |
| | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnant, If yes # of weeks _____ |

Please discuss any medical problems that your child has had. _____

☺DENTAL HISTORY☺

Patient's Dentist _____ Date last visit _____

Has your child ever had or been evaluated for orthodontic treatment? Yes No Please explain _____

What are your main orthodontic concerns?

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

Does your child have any of the following habits? (Please check)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Thumb / Finger Sucking | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Lip Sucking / Biting | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Clenching / Grinding Teeth | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Nursing Bottle Habit | <input type="checkbox"/> Tongue Thrust |
| <input type="checkbox"/> Forcing Jaw to Pop | | | |

Has your child ever had a problem associated with previous dental work? Yes No

Has your child ever had pain/tenderness in his/her jaw joint (TMJ)? Yes No

How many times a day does your child brush his/her teeth? _____ Does he/she floss daily Yes No

Have there been any injuries to the Face Mouth Teeth Chin Are any teeth loose? Yes No

Has your child had x-rays taken of all his/her teeth in the past year? Yes No

Does your child have any missing or extra permanent teeth? Yes No

List any musical instruments played _____

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 child's medical status. I authorize the dental staff to perform any necessary orthodontic services my child may 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 pertains to my child's 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: _____

***** 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 _____ @ _____