Lisa King, D.D.S., M.S. **WELCOME!** **Acct#_____**

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 / Epilepsy
❑ 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.

____

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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____

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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: ____

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

Initials__________________________________ Date _______________

Estimate: $__________ to $___________ Next Appt.______________________ Scheduled__________ @___________