Lisa King, D.D.S., M.S. **WELCOME**

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

❑ Yes ❑ No Severe / Frequent Headaches
❑ Yes ❑ No Sexually Transmitted Disease
❑ Yes ❑ No Ulcers / Colitis
❑ Yes ❑ No Difficulty Breathing / Pneumonia

❑ Yes ❑ No Psychiatric Problems / Nervous Disorder
❑ Yes ❑ No Hemophilia / Prolonged Bleeding
❑ Yes ❑ No Anemia / Fainting or Dizziness
❑ Yes ❑ No Glaucoma / Eye Problems
❑ Yes ❑ 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?

❑ 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_____

_____

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

❑ Thumb / Finger Sucking ❑ Mouth Breathing ❑ Lip Sucking / Biting ❑ Speech Problems
❑ Clenching / Grinding Teeth ❑ Nail Biting ❑ Nursing Bottle Habit ❑ Tongue Thrust
❑ 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_____@_____