Kathy Lee, D.D.S.
Specialist in Orthodontics

Welcome to Orthodontics

Shaun Woo, D.D.S.
Specialist in Orthodontics

Tell Us About Your Child

Today's Date:_____ ( ) Male ( ) Female

Name:_____
Last First MI

Nickname: _____

Birthdate: _____ /_____ /_____ Age:_____

School: _____ Grade: _____

Hobbies/ Sports: _____

Home Address: _____

_____
City State Zip

Who Is Accompanying Your Child Today

Name: _____ Relation: _____

Do you have legal custody of this child? ( ) Yes ( ) No

Whom may we Thank for referring you? _____

List siblings with age: _____

_____

General Dentist: _____

Date of Last Visit: _____

Mother's Information: ( ) Step Mother ( ) Guardian

Name: _____Birthdate:____/____/____

Hm# _____ Cell# _____

Email address: _____

Employer : _____ Job Title: _____

Father's Information: ( ) Step Father ( ) Guardian

Name: _____Birthdate:____/____/____

Hm# _____ Cell# _____

Email address: _____

Employer : _____ Job Title: _____

Parent's Marital Status: ( ) Single ( ) Married
( ) Divorced ( ) Separated ( ) Widowed

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Hm#: _____ DL#: _____

Cell#: _____ Wk#: _____

Email address: _____

Employer: _____

Who is Responsible for making appointments:

Name: _____

Hm# _____ Cell# _____

Primary Orthodontic Insurance

Orthodontic Coverage? ( ) Yes ( ) No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

DOB: _____/_____/_____ **ID/SS#:** _____

Employer: _____

Relationship to Patient: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ( ) Yes ( ) No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

DOB: _____/_____/_____ **ID/SS#:** _____

Employer: _____

Relationship to Patient: _____

What are the main concerns you would like us to accomplish?

_____

_____

_____

Has your child ever been evaluated or had orthodontic treatment in the past? ( ) Yes ( ) No

Has there been any injuries to the face, mouth, teeth or chin? ( ) Yes ( ) No

List any musical instruments played: _____

Has had tonsil and/or adenoids removed? ( ) Yes ( ) No

Has your child been informed of any missing or extra permanent teeth? ( ) Yes ( ) No

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

Does your child brush his/ her teeth daily? ( ) Yes ( ) No

Does your child floss his/ her teeth daily? ( ) Yes ( ) No

Child's Physician: _____

Phone #: _____

Is your child under the care of a physician? ( ) Yes ( ) No

Has begun puberty? ( ) Yes ( ) No

Has begun menstruation? (Girls) ( ) Yes ( ) No

Please describe you child's current physical health:

( ) Good ( ) Fair ( ) Poor

Please list all drugs that your child is currently taking: _____

_____

Please list any ALLERGIES your child may have: _____

_____

_____

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Hospital stays	Y	N	Handicap/ Disabilities
Y	N	Operations	Y	N	Hearing Impairment
Y	N	Asthma	Y	N	Heart Murmur
Y	N	Cancer	Y	N	Hemophilia
Y	N	Congenital Heart Defect	Y	N	Hepatitis
Y	N	Convulsions/ Epilepsy	Y	N	HIV +/ AIDS
Y	N	Kidney/ Liver Problems	Y	N	H1N1 Virus (Swine Flu)
Y	N	Rheumatic/ Scarlet Fever	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

Does your child have any of the Following habits?

Y	N	Clenching/ Grinding teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking/ Biting	Y	N	Speech Problems
Y	N	Thumb/ Finger Sucking	Y	N	Mouth Breather
Y	N	Nail Biting	Y	N	Tongue Thrusting

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her name: _____

Relation: _____

Hm # :_____

Wk #:_____

I understand that the information that I have given about my child is correct to the best of my knowledge, that it will be held in the strictest of 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 dental services that my child may need during diagnosis and treatment with my Informed consent.

Signature: _____ Date: _____

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I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.
Doctor's Comments:

_____

Doctor's Signature: _____ Date: _____

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