Enriching Lives and Smiles

James C. Lyles, DDS, Inc.
Orthodontics - Facial Orthopedics

Welcome

Patient Information - Child

Date ____/____/________ Male / Female

Patient's Name ____ Preferred Name ___________________

Address ___________________________________City __________________State _______Zip_______________

Home Phone _________________________ Birthdate _____/_____/_____ Social Security # _____/_____/_____

E-mail Address ___________________________________

Whom may we thank for referring you to our office?

Responsible Party Information

Primary's Name ____ Marital Status_____________

Address ___________________________________City _________________State ________Zip_______________

How long at address ______ Home Ph _______________ Work Ph _______________ Alternative Ph _____________

Previous Address (if less than 3yrs) ____

Social Security No. ______/_____/______ Birthdate _____/_____/_____ Relationship to Patient __________________

Employer _________________________________ Occupation _____________________ No. Yrs Employed ______

Secondary's Name ____ Marital Status _____________

Address ___________________________________City _________________State _______Zip_______________

How long at address ______ Home Ph _______________ Work Ph _______________ Alternative Ph _____________

Previous Address (if less than 3yrs) ____

Social Security No. ______/_____/______ Birthdate _____/_____/_____ Relationship to Patient ___________________

Employer ________________________________ Occupation ______________________ No. Yrs Employed ______

Who has legal custody, if divorced:

Insurance Information

Insured's Name ____ Insured's Soc. Sec. #_______/______/_______

Insurance Company ____ Group # __________ Ph # ________________

Insurance Co. Address ____

Emergency Information

Name of nearest relative not living with you ____

Complete Address ____ Ph # ________________

Relationship ______________________________

I understand that where appropriate, credit bureau reports may be obtained.

Responsible Party Signature ____

E-mail Address ____

CONFIDENTIAL (for record and pretreatment evaluation)

Main concerns you would like to address ____

Patient's concerns are ____

School your child attends ___________________ Musical instruments played __________________

Hobbies / Sports ____

Please list brothers / sisters with age ____

Child's General Dentist _____________________________________ Date of last visit ___/___/___

Has your child ever been evaluated for or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

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

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

Does your child brush / floss daily? Yes No

Have adenoids or tonsils been removed? Yes No

Does your child have any speech problems? Yes No

Does your child generally breathe through his / her mouth? Yes No

Child's Physician ____ Phone__________________

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

Please describe your child's current physical health Good Fair Poor

List any prescription or over the counter drugs being taken__________________________________

Please list all drugs/things to which your child is **allergic**____________________________________

Has Your Child Ever Had Any Of The Following Medical Problems? (Please Circle)

Abnormal Bleeding
Allergies to any Drugs
Allergic to Latex/Metals
Allergic to Plastic
Asthma
Cancer
Congenital Heart Defect
Convulsions/Epilepsy

Diabetes
Handicaps/Disabilities
Hearing Impairment
Heart Murmur
Hemophilia
Hepatitis
HIV+ / AIDS
Kidney/Liver Problems

Rheumatic/Scarlet Fever
Tuberculosis
None
Other ________________
____
____

Please discuss any medical problems that your child has had ________________________________

Does / Did Your Child Have Any Of The Follow Habits? (Please Circle)

Clenching / Grinding Teeth
Nail Biting

Lip Sucking / Biting
Thumb / Finger Sucking

Nursing Bottle Habits
Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

X ____