Oasis Orthodontics
Smile.

Dr. Lisa M. Austin, DMD, MSD
Orthodontics for Children and Adults

10050 W 41st. Ave. Suite 102 **Wheat Ridge, CO** 80033
(303)940-5659

About you and your child

Today's Date _____
Child's Name _____
Last First MI
Prefers to be called _____
Birthdate _____ Age ____ ☐ Male ☐ Female
School _____ Grade _____
Hobbies/Sports _____
Home Phone # _____
Home Address _____
City/State/Zip _____

☐**Mother** ☐ **Step Mother** ☐**Guardian**
Name _____
Birthdate _____
Cell # _____ Work #_____
Employer/Title _____
SS# _____
Email _____

☐**Father** ☐ **Step Father** ☐**Guardian**
Name _____
Birthdate _____
Cell # _____ Work #_____
Employer/Title _____
SS# _____
Email _____

Who will be responsible for making appointments?
_____
Who will be responsible for the account?
_____

Who is Accompanying the Patient Today?

Name _____
Relation _____
Parent's marital status _____
Do you have legal custody of this child? ☐Yes☐no
Whom may we thank for referring you to us?
_____
Other family members seen by us include
_____

Dental Insurance

Primary Dental Insurance
Insurance Co _____
Insurance Address _____
Phone # on card _____
ID # _____
Group # _____
Policy Holder's Birthdate _____
SS# _____
Relationship to Patient _____
Policy Holder's Employer _____

Secondary Dental Insurance
Insurance Co _____
Insurance Address _____
Phone # on card _____
ID # _____
Group # _____
Policy Holder's Birthdate _____
SS# _____
Relationship to Patient _____
Policy Holder's Employer _____

General Dentist _____

Located at/near _____

Date of last checkup/cleaning _____

Health History

Has this patient ever had any of the following medical problems?

- ☐Abnormal bleeding
- ☐Allergies to any drugs
- ☐Latex/Metal allergy
- ☐Plastic allergy
- ☐Asthma
- ☐Cancer
- ☐Congenital Heart Defects
- ☐Kidney/Liver Problems
- ☐Diabetes
- ☐Convulsions/Epilepsy
- ☐Handicaps/Disabilities
- ☐Rheumatic/Scarlet Fever
- ☐Hearing impairment
- ☐Heart Murmur
- ☐Hemophilia
- ☐Hepatitis
- ☐HIV+/AIDS
- ☐Hospitalization
- ☐Tuberculosis
- ☐Operations

_____

_____

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

Name of physician?
_____

Physician's phone number
_____

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

Please list all drugs your child is currently taking:
_____

Please list any drugs/or other that your child is allergic to:
_____

Please discuss any medical problems that your child has had that we should be aware of: _____
_____

Has the patient ever been evaluated for or had orthodontic treatment before?
☐Yes ☐no

Have there been any injuries to the face, mouth or chin?
☐Yes ☐no

Have you ever been informed that the patient has any missing or extra permanent teeth?
☐Yes ☐no

Has the patient ever had any pain or tenderness in his/her jaw joint? (also referred to as TMJ/TMD)
☐Yes ☐no

Does the patient brush his/her teeth daily?
☐Yes ☐no

Floss teeth regularly?
☐Yes ☐no

Has puberty begun?
☐Yes ☐no

Has menstruation begun? (Girls)
☐Yes ☐no

Does the patient have, or have they ever had any of the following habits?

- ☐Clenching/grinding
- ☐Nail Biting
- ☐Mouth breathing
- ☐Soda pop drinker
- ☐Nursing/bottle habits
- ☐Lip sucking/biting
- ☐Tongue thrust
- ☐Thumb/finger sucking

What are your main concerns that you would like orthodontics to accomplish?

_____

We are sorry, but we cannot accept divorce decrees as assignments of responsibility for a child's bill. The parent accompanying the child should pay for services and seek any reimbursement from the other parent.

I understand that this information is correct and will be held in confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services the patient may need during diagnosis and treatment with my informed consent.

Legal Name Signature: