Dr. Roy K. King, P.A.
JUPITER ORTHODONTICS

Please print out and mail to:
24 N. LOXAHATCHEE DRIVE • SUITE 4 • JUPITER, FLORIDA 33458
TELEPHONE 561/747-5766
or fax to 561-744-2158

FAMILY CARE PROGRAM

Dear Parent:

As a service to our patients and parents we are pleased to announce our FAMILY CARE PROGRAM.

Dental and orthodontic research has shown that just as a child's first dental appointment should be at approximately 3 years of age, an initial orthodontic examination at 7 or 8 years of age can often reveal subtle, but important discrepancies in the development of the bite and the eruption of teeth.

When we examine a child early, before the permanent teeth become too crowded or spaced, or before jaw growth has had any significant negative effect on the bite, we are often able to get the child back on the path of normal growth and development with some timely decisions.

When a family is established with our practice, we feel parents need not wait for a dental referral before their children have an orthodontic evaluation. As a service to our current patients, we will be happy to follow any children in your family, who have not yet been seen, as part of this FAMILY CARE PROGRAM. If you will simply complete the patient data sheet and return it to our office, we will enter the children into the program and we will contact you at the appropriate time, usually at age 7, to schedule an initial visit.

There are no fees for any visits while your child is in this program unless a special panoramic x-ray is needed and of course, there is never any obligation on your part.

We are happy to offer this service to our current patients and parents, and welcome your participation.

Instructions:

Complete data for all children in your family (any age) who could benefit from the program. Please do not give any information for any children who have already been seen (even once) by Dr. King for an orthodontic examination. After completing your patient data sheet, please return it to us and we will then contact you at the appropriate time for each child's initial visit.

Thank you and please do not hesitate to let us know if you have any questions regarding our program.

Name of Child (First/Last)	Date of Birth (month/day/year)
1._____	___/___/_____
2._____	___/___/_____
3._____	___/___/_____
4._____	___/___/_____

PLEASE FILL OUT THE ADDITIONAL INFORMATION BELOW

PARENTS NAME: _____

ADDRESS: _____

HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____

FAMILY DENTIST: _____