

PARKS & SCHMIT
ORTHODONTICS

Clayton T. Parks, D.D.S., M.S.

Jason L. Schmit, D.D.S., M.S.

Jessica K. Fuller, D.D.S., M.S.

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Adult

Patient's Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ Male Female

Home Phone _____ Cell Phone _____

Home Address _____ City _____ ST _____ ZIP _____
Street

General Dentist _____

How did you hear about our office/whom may we thank for recommending our office? _____

Have we treated another member of your family? YES NO If YES, Name(s) _____

Have you visited an orthodontist before? YES NO If YES, for what reason? _____

Would You Like To Receive Text Messages? Yes No

Primary Insurance Information

Insured's Employer _____ Occupation _____

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____ Group or Plan # _____

Secondary Insurance Information

Insured's Employer _____ Occupation _____

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS # _____ Group or Plan # _____

To access your personal account and appointment information through our website and to receive email confirmation of appointments please provide your email address(es): _____

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? YES NO If YES, please describe _____

Any sensitivities or allergies? YES NO If YES, please list _____

Currently taking any medications? YES NO If YES, please list _____

Have you been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis	Thyroid
Asthma	Cancer	Epilepsy	Nervous Disorder	High Blood Pressure	

Has your physician/dentist recommended antibiotics before dental treatment? YES NO If YES, medication: _____

Have there been injuries to your face, mouth or chin? YES NO If YES, explain: _____

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD) YES NO If YES, explain: _____

Do/Did you have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Chronic Mouth Breathing	Speech Problems	Chewing/Eating Problems
Tobacco Use		

Are there other dental issues not listed that you would like to discuss or have treated? NO YES If YES, please explain: _____

Your "Smile" Questionnaire

What changes would you like to see with your teeth? _____

Are you concerned with (circle all responses):

Teeth that are crooked or crowded? NO YES

Spaces between your teeth? NO YES

Your front teeth "sticking out too much"? NO YES

Too much or too little gum tissue showing when you smile? NO YES

An overbite? NO YES

Teeth not white enough? NO YES

Signature

I understand that the information that I have provided 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 medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature _____ Date _____