

PARKS & SCHMIT ORTHODONTICS

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We would like to welcome you and your child 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 - Child or Teen

Patient's Name _____ Age _____ Birth Date _____
First Middle Last
 Nickname (if preferred) _____ Male Female Patient's Home Phone _____
 Patient's Home Address _____ City, State, ZIP _____
 Who is completing this form? Name _____
First Middle Last
 Relationship _____ Do you have legal custody? YES NO Patient's Dentist _____
 Who may we thank for recommending our office? _____
 Have we treated or seen another member of your family? YES NO If YES, Name(s) _____

 Has your child visited an orthodontist before? YES NO If YES, for what reason? _____

Parent Information

Marital Status:			Single	Married	Widowed	Divorced	Separated	Domestic Partner
Father _____ Name _____ Address _____ Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____	Step Father _____ Name _____ Address _____ Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____	Guardian _____ Name _____ Address _____ Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____	Mother _____ Name _____ Address _____ Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____	Step Mother _____ Name _____ Address _____ Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____	Guardian _____ Name _____ Address _____ Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____			

Insurance Information

PRIMARY CARRIER: _____ Employer: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____
 SECONDARY CARRIER: _____ Employer: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

To receive email confirmation of appointments, please provide your email address(es): _____

Dental and Medical History

Is your child currently under the care of a physician? YES NO If YES, for what reason? _____

Child's 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 _____

Has the child been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	

Has your physician/dentist recommended your child take antibiotics before dental treatment? YES NO If YES, which antibiotic: _____

Have adenoids or tonsils been removed? YES NO

For growth assessment, has menstruation (period) begun? YES NO NOT APPLICABLE

Have you been informed of any missing or extra teeth? YES NO

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

Has your child ever had any primary (baby) teeth removed by their dentist? YES NO

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD) YES NO If YES, explain: _____

Does/Did the child have any of the following current habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Mouth Breather	Speech Problems	Chewing/Eating Problems

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 or your child like to see with their teeth? _____

Are you concerned with (circle all responses):

An overbite? NO YES

Teeth that are crooked or crowded? NO YES

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

Spaces between your teeth? NO YES

Too much or too little gum tissue showing when you smile? 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 child's 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 _____