PARKS & SCHMIT
ORTHODONTICS

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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? ______________________

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 ____________________