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 ______ (First) ______ (Middle) ______ (Last) Age ______ Birth Date ______

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 Step Father Guardian	Mother Step Mother Guardian
Name ______	Name ______
Address ______	Address ______
Birthdate ______	Birthdate ______
Home Phone ______	Home Phone ______
Cell Phone ______	Cell Phone ______
Work Phone ______	Work Phone ______
Email ______	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 ____________________