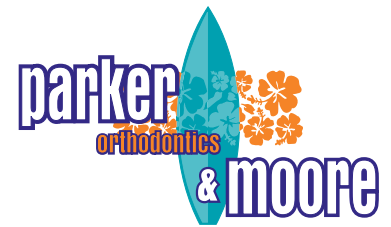


Welcome



About the Patient

Patient's Last Name (Please Print)	First	Middle Initial	Patient prefers to be called	Sex (M or F)	Exam Date
Home Address	Street	City	State	Zip Code	Home Phone Number
Patient's Age	Patient's Birthdate	Best Phone Number For this Office to Use (Please check box)			
		<input type="checkbox"/> Home		<input type="checkbox"/> Cell	
				<input type="checkbox"/> Work	

This section is for patients under 18 years of age - Parent or guardian please complete

Marital Status of Mother and Father <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Who is accompanying the patient today?		
Father's Name	Father's Social Security Number	Father's Employer	Work Phone#		
Mother's Name	Mother's Social Security Number	Mother's Employer	Work Phone#		
Name of Brothers and/or Sisters	Age	Name	Age	Name	Age

Adult Patients - Please complete this section

Employer	Work Address	Work Phone #
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed/Divorced	If Married, Name of Spouse	Spouse's Social Security Number
Spouse's Employer	Spouse's Work Phone #	

Person responsible for the account

Last Name (Please Print)	First	Middle Initial	Social Security Number	Relationship to Patient
Billing Address:	Street	City	State	Zip Code
				Home Phone #
Employer	Work Address	Work Phone #		

Orthodontic Insurance (Primary)

Insurance Company's Name	Group # (Plan, Local, or Policy #)	Phone #
Insured's Name	Insured's Birthdate	Insured's Social Security Number
Insured's Employer	Insured's Relationship to Patient	
Insured's Address		

Orthodontic Insurance (Secondary)

Insurance Company's Name	Group # (Plan, Local, or Policy #)	Insurance Company's Phone #
Insured's Name	Insured's Birthdate	Insured's Social Security Number
Insured's Employer	Insured's Relationship to Patient	
Insured's Address		

Email Address

Parent/or Adult Patient	Parent/or Adult Patient
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Who may we thank for referring you?

Name	Address / Phone Number
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Other family members treated by Dr. Stan Parker / Dr. Cody Moore

Medical History

<p>Have you had any of the medical problems listed? If yes to any question, please explain.</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding problems</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Respiratory Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergic to anything in dental office</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Handicaps or disabilities</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you ever been hospitalized</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you taking any medications</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you <u>ever</u> been treated for osteoporosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you <u>ever</u> had intravenous treatment for cancer or osteoporosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you <u>ever</u> taken the following drugs Fosamax, Actonel, Aredia, Boniva, Zometa, etc.</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you ever been treated for cancer</p>	<p>Explain</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Patient's Dentist is:	Date of Last Dental Cleaning
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Dental History

If yes to any question, please explain

Yes No

Is there any dental work in progress?

Have you experienced any gum tissue problems? Bleeding?

Do you need antibiotics before dental cleaning or visits?

Habits such as clenching, grinding, nail biting, tongue thrust, mouth breathing, or thumb-sucking? (circle those that apply)

Jaw joint problems or TMJ?

Have you ever been evaluated for or had orthodontic treatment before?

I certify that the information that I provided today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental services that I/my child may need during diagnosis and treatment.

Signature of Responsible Party _____ Date _____

Signature of Orthodontist _____ Date _____