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)
	/ /	❑ Home _____ ❑ Cell _____ ❑ Work _____

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

Marital Status of Mother and Father	Who is accompanying the patient today?
❑ Married ❑ Divorced ❑ Separated ❑ Widowed	

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	If Married, Name of Spouse	Spouse's Social Security Number
❑ Single ❑ Married ❑ Widowed/Divorced		

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

Who may we thank for referring you?

Name	Address / Phone Number

Other family members treated by Dr. Stan Parker / Dr. Cody Moore

Medical History

Have you had any of the medical problems listed?
If yes to any question, please explain.

Yes	No		Explain
❑	❑	High Blood Pressure	
❑	❑	Heart Problems	
❑	❑	Bleeding problems	
❑	❑	HIV/AIDS	
❑	❑	Hepatitis	
❑	❑	Rheumatic Fever	
❑	❑	Drug Allergies	
❑	❑	Respiratory Allergies	
❑	❑	Latex Allergies	
❑	❑	Allergic to anything in dental office	
❑	❑	Joint problems	
❑	❑	Artificial joints	
❑	❑	Handicaps or disabilities	
❑	❑	Have you ever been hospitalized	
❑	❑	Are you taking any medications	
❑	❑	Have you ever been treated for osteoporosis	
❑	❑	Have you ever had intravenous treatment for cancer or osteoporosis	
❑	❑	Have you ever taken the following drugs	
		Fosamax, Actonel, Aredia, Boniva, Zometa, etc.	
❑	❑	Have you ever been treated for cancer	

Patient's Dentist is:	Date of Last Dental Cleaning
	/ /

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 _____