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 ❑ Married ❑ Divorced ❑ Separated ❑ 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 ❑ Single ❑ Married ❑ 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

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 _____