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PARKER ORTHODONTICS
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SUITE 190
ST. JOSEPH, MO 64506
816-232-6112

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

Continued on back

1 Tell Us About Your Child

Today's Date:_____ Email:_____

Child's Name: _____
LAST FIRST MI

Birthdate: ___/___/___ Age: _____ ☐ Male ☐ Female

School:_____ Grade:_____

Child's Home #: (___) _____

Child's Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

2 Who is Accompanying Your Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you?_____

List brothers / sisters with age:_____

_____

General Dentist:_____

Last Visit Date:_____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

3 ☐ Mother's Information

☐ Step Mother ☐ Guardian

Name:_____ Birthdate: ___/___/___

Cell #: (___) _____ Home #: (___) _____

Address _____

Employer _____

SS#:_____ DL#:_____

Email: _____

☐ Father's Information ☐ Step Father ☐ Guardian

Name:_____ Birthdate: ___/___/___

Cell #: (___) _____ Home #: (___) _____

Address _____

Employer _____

SS#:_____ DL#:_____

Email:_____

4 Additional Information

☐ Step Mother ☐ Guardian

Name:_____ Birthdate: ___/___/___

Wk #: (___) _____ Ext:___ Home #: (___) _____

Address _____

Employer _____

SS#:_____

☐ Additional Information ☐ Step Father ☐ Guardian

Name:_____ Birthdate: ___/___/___

Wk #: (___) _____ Ext:___ Home #: (___) _____

Address _____

Employer _____

SS#:_____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address:_____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #):_____

Policy Owner's Name:_____

Relationship to Patient: _____

Policy Owner's Birthdate:___/___/___ ID #_____

Policy Owner's Employer _____

Employer's Address:_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #):_____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate:___/___/___ ID #_____

Policy Owner's Employer _____

Employer's Address:_____

6 What are the main concerns that you would like orthodontics to accomplish?

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If yes, when? _____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids ☐ tonsils ☐ been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has you child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does you child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: (____) _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs / things that your child is allergic to: _____

_____

Y N Latex Y N Metals/Nickel Y N Plastics

7 Has you child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy
Y	N	ADD / ADHD	Y	N	Diabetes
Y	N	Allergies to any Drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones / Joints / Valves	Y	N	HIV+ / AIDS
			Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Lupus
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

_____

_____

8 Has you child ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Neighbor or Relative not living with you.

Name _____ Phone (____) _____

Address _____

_____

CITY STATE ZIP

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I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I have received notice of this office's Notice of Privacy Practices

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

The Parent or Guardain who accompanies the child is responsible for payment.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: Initials: _____ Date: _____

_____

_____

_____