Lisa M. Parker, D.D.S., P.C.
PARKER ORTHODONTICS
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SUITE 190
ST. JOSEPH, MO 64506
816-232-6112

Welcome!

The benefits of a happy, healthy smile are immeasurable!
A beautiful smile is a wonderful asset.
Please fill out this form completely.
The better we communicate, the better we can care for you.

Continued on back

1 ABOUT YOU

Today's Date: _____

Email Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS# _____

Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (___) _____ Pager/Other #: (___) _____

Wk #: (___) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk #: (___) _____ Ext: ____ SS #: _____

Birthdate: ___/___/___

Person Responsible for Account:

Wk #: (___) _____ Ext: ____ Hm #: (___) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

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

Insured's Name: _____ Relation _____

Insured's Birthdate: ___/___/___ Insured's ID # _____

Insured's Employer: _____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

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

Insured's Name: _____ Relation _____

Insured's Birthdate: ___/___/___ Insured's ID # _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation _____

Wk #: (___) _____ Hm #: (___) _____

4 MEDICAL HISTORY

Do you have a personal physician ☐ Yes ☐ No

Physician's Name: _____

Phone #: (___) _____ Date of last visit: _____

4 MEDICAL HISTORY *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women:
Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma/Arthritis	Y	N	HIV+/AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for Any Reason
Y	N	Cancer/Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug/Alcohol Abuse	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Severe/Frequent Headaches
Y	N	Epilepsy/Seizures/Fainting	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack/Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers/Colitis
Y	N	Heart Surgery/Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Any Metals/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: _____

5 DENTAL HISTORY

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth ☐ Yes ☐ No

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin)

If yes, when? _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

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 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.
I understand that I am 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 patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____