PARKWAY ORTHODONTICS

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____

Nickname_____ Birthdate _____ Male Female

Address _____ City_____ State_____ Zip_____

Patient's Cell Phone_____ Name of School_____

Does patient live with Father/ Mother/ Guardian or Other?_____

What is your preferred method of contact: Phone Call / Text / Email_____

FAMILY INFORMATION

Other family members treated in our office_____

Father / Step-Father / Guardian (please circle)

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Business Phone_____

Email_____ Birthdate _____ Social Security #_____

Employer _____ Occupation_____ Years Employed_____

Mother / Step-Mother / Guardian (please circle)

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Business Phone_____

Email_____ Birthdate _____ Social Security #_____

Employer _____ Occupation_____ Years Employed_____

Additional Responsible Party **Relationship to patient**_____

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Business Phone_____

Email_____ Birthdate _____ Social Security # _____

Employer _____ Occupation_____ Years Employed_____

In case of emergency, please list someone other than those above who will know how or where to contact you.

Name_____ Relationship_____ Phone Number_____

Reason for Visit_____

How did you hear about us or whom may we thank for referring you?_____

INSURANCE

Is the patient covered by a group or private dental insurance plan? ____ Yes ____No If yes, please complete a Signature on File form.

Is the patient covered by South Dakota Medicaid? ____Yes ____No If yes, Patient's ID# _____

MEDICAL INFORMATION

Patient's Physician_____City_____Date of Last Visit_____

Patient's Dentist_____City_____Date of Last Visit_____

Pharmacy_____Location_____

For Females: Are you pregnant?_____

List any medications you are currently taking_____

List any allergies to food/medicine/metals_____

List any hospitalizations or surgeries_____

Have you ever had a serious injury to your head or neck?_____

Have you had any injuries to your teeth or jaws? (falls, blows, chips, etc.)_____

Are you currently under the care of a physician? If so, for what?_____

_____

Do you have a history of: ___Lip sucking ____Mouth Breathing ____Thumb Sucking ___ Nail Biting ____Pacifier ____Finger Sucking

Please check if you have a history of any of the following:

___Asthma / Respiratory problems	___ADD / ADHD	___Behavioral issues
___Bleeding / Blood disorders	___Cancer	___Developmentally Delayed
___Diabetes	___Eating Disorders	___Epilepsy
___Gastric reflux / Stomach disorders	___Heart trouble / Murmurs	___Hepatitis / AIDS
___Kidney / Liver issues	___Latex Allergy	___Seizures / Convulsions

___Other

Additional information you feel may be pertinent to your treatment_____

_____

I acknowledge that I have completed this form, read and answered the questions to the best of my knowledge. I will inform this practice of any changes to this record or my medical/dental status. I understand that if appropriate, credit bureau reports may be obtained.

_____ _____

Signature of responsible party Date