

Patient Information

Date _____

Patient's _____
Last First MiddleAddress _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party InformationName _____
Last First Middle Marital StatusResidence _____
Street City State ZipMailing Address _____
Street City State Zip

How long at this address? _____ Home # _____ Work # _____

Cell Phone # _____ Email Address _____

Previous address (If less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ # of Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ # of Years Employed _____

Social Security # _____ Birthdate _____ Work # _____

Insurance Information

Insured's Name _____ Insured's SS # _____

Insurance Company _____ Group # _____ Ins Co. Phone # _____

Insurance Co.address _____

Do you have dual coverage? ___ Yes ___ No If yes:

Insured's Name _____ Insured's SS # _____

Insurance Company _____ Group # _____ Ins Co. Phone # _____

Insured's Employer _____

Emergency Contact Information (other than responsible parties)

Name _____ Relation _____

Complete Address _____

Phone # _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

THANK YOU FOR SUPPLYING THE ABOVE INFORMATION
MELANIE PARKER DDS, MS, INC**CHILD GET ACQUAINTED QUESTIONNAIRE**

Sex: _____ Age: _____ Birthdate: _____ Height: _____ Weight: _____

Ethnicity : Anglo American _____ African American _____ American Indian _____
Asian _____ Chinese _____ Japanese _____ Korean _____ Pacific Islander _____ Latin _____
We need ethnicity information for diagnosis purposes only.

School: _____ Grade: _____ Scholastic Performance: _____
Like or dislike school? _____
Had unfavorable reaction to dental care? _____
Reason for consultation? _____
Does patient desire orthodontic treatment? _____

GENERAL HEALTH

Any history of (circle the condition): Heart trouble, heart murmur, rheumatic fever, allergies, hepatitis, positive HIV, diabetes, asthma, kidney or liver involvement, epilepsy, bleeding disorders, mental disorders, etc.? _____

Has patient had any operations? _____

Is patient presently taking any medications? (Rx, over the counter or herbal) _____

Have you ever had an allergic reaction to any medications? _____

If so, what medications? _____

Is patient sensitive to latex? _____

Has it ever been recommended that the patient take antibiotics prior to dental procedures? _____

Any previous orthodontic treatment? _____

Accidents/Trauma to mouth or teeth? _____

ORAL HABITS: Thumb sucking, etc? _____ Nail biting? _____

Mouth breathing? _____ Lip or tongue biting? _____

VOICE: Speech: _____ Stammer: _____ Lisp: _____

PRESENT HEALTH: Excellent: _____ Good: _____ Fair: _____ Poor: _____

Patient's dentist: _____ Patient's physician: _____

Brother(s) & Sister(s), names & ages: _____

Any orthodontic problems? _____ Treated? _____

Does **Father** have orthodontic problems? _____ Treated? _____

Does **Mother** have orthodontic problems? _____ Treated? _____

Responsible Party's Email address _____

Health History Update:

Date: _____ Date: _____ Date: _____

Initials: _____ Initials: _____ Initials: _____

Changes: _____ Changes: _____ Changes: _____