PARKER
ORTHODONTICS

Joseph D. Parker, DDS, MSD
315 N. Sprague St. Ellensburg, WA 98926
Office: 509.962.6902

Adult Patient Information

Patient's Name _____Today's Date_____
Birthdate___/___/___ Age____ ❑ M ❑ F Email Address _____
Mailing Address _____ City _____ State ___ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____Occupation _____ Years Employed _____
General Dentist _____ Date of last dental Check Up _____
Whom may we thank for referring you to our office? _____
HOW WOULD YOU LIKE YOUR APPOINTMENTS TO BE CONFIRMED? ❑ Text ❑Email ❑ Phone Call

Responsible Party Information

❑Self ❑Spouse ❑Other Name _____ ❑ Single ❑Married ❑Divorced
Address _____ City _____ State ___ _ Zip _____
Home Phone _____ Work Phone _____ Cell _____
Social Security Number ____-____-_____ Birthdate ___/___/___ Relationship to Patient_____
Employer _____ Occupation _____ Years Employed _____

Dental Insurance Information

Primary Dental Insurance _____ Subscriber's Date of Birth ___/___/____
Subscriber's Name _____ SSN _____-_____-_____
ID Number _____ Group Number _____
Do you have dual coverage? ❑ Yes ❑ No If yes, please see below.
Secondary Dental Insurance _____ Subscriber's Date of Birth___/___/____
Subscriber's Name _____ SSN _____-_____-_____
ID Number _____ Group Number _____

Please note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company. ** **Office Policy** : Should you decide to finance through our office, your SSN will need to be on file.

Emergency Contact Information

Name _____ Phone _____Relation _____

Dental History

Are you interested in: (please indicate all that apply)

❑ Information ❑ Treatment now ❑ Clarification of previous or conflicting information

What is your chief concern? _____

1.	Have there been injuries to the face, mouth, or teeth?	❑ Yes	❑ No
2.	Do you have any speech problems?	❑ Yes	❑ No
3.	Have you been informed of any missing or extra permanent teeth?	❑ Yes	❑ No
4.	Has any previous orthodontic treatment been rendered?	❑ Yes	❑ No
5.	Do you suffer from any jaw joint problems such as pain, clicking, popping, etc.?	❑ Yes	❑ No
6.	Do you grind or clench your teeth during the day or night?	❑ Yes	❑ No
7.	Teeth difficult to clean?	❑ Yes	❑ No
8.	Awareness of any gum or bone problem around teeth?	❑ Yes	❑ No
9.	Concerned about the appearance of your teeth?	❑ Yes	❑ No

Other:_____

_____

Medical History

Name of your physician _____ Date of last exam_____

1. Is the patient in good health? ❑Yes ❑No
2. Does the patient have a health problem? ❑Yes ❑No If yes, explain_____
3. Does the patient have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc,)?

❑Yes ❑No If yes, please list: _____

4. Please list any current prescription medications: _____
5. Pregnant? ❑Yes ❑ No If so, Current trimester: _____
6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)

❑ Problems at Birth	❑ Hepatitis/Liver Disease	❑ Seizures
❑ Heart Disease/Murmur	❑ Tuberculosis	❑ Cleft Lip/Palate
❑ Rheumatic Fever	❑ Kidney Disease	❑ Speech or Hearing Problems
❑ Sickle Cell Anemia	❑ Cancer/Radiation Therapy	❑ Tonsil, Adenoid, Sinus Problems
❑ Anemia/Hemophilia	❑ Cerebral Palsy	❑ Emotional/Behavior Problems
❑ Diabetes	❑ Arthritis	❑ Learning Disabilities
❑ AIDS or HIV	❑ Asthma	❑ Growth Problems

Other:_____

_____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.

Responsible party signature _ _____Date_____