



JOSEPH D. PARKER, DDS, MSD
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Office: (509) 248-5181

Child Patient Information (under 18 years)

Patient's Name _____ Today's Date _____
Mailing Address _____ City _____ State _____ Zip _____
Nickname _____ Birth Date ____/____/____ Age _____ M F
Grade _____ School _____ Dentist _____
Whom may we thank for referring you to our office? _____
COURTESY REMINDERS: Text Number(s): _____ Email: _____

Responsible Party Information

Name _____ Single Married Divorced Separated
Mailing Address _____ City _____ State _____ Zip _____ Yrs _____
Email Address: _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Relationship to Patient _____
Employer _____ Occupation _____ No. years employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. years employed _____
Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Birth Date ____/____/____ SSN ____ - ____ - ____
Insurance Company _____ Group No. _____ Phone No. _____
Do you have dual coverage? Yes _____ No: _____ If yes:
Insured's Name _____ Birth Date ____/____/____ SSN ____ - ____ - ____
Insurance Company _____ Group No. _____ Phone _____

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: Your Social Security Number will need to be on file should you decide to finance through our office.**

Emergency Contact Information

Name of nearest relative not living with you _____ Phone _____
Please continue to the back

Dental History

What is your chief concern? _____

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

Information Treatment now Clarification of previous or conflicting information

1. Have there been injuries to the face, mouth, or teeth? Yes No
2. Does the patient have any speech problems? Yes No
3. Has the patient ever been informed of any missing or extra permanent teeth? Yes No
4. Has any previous orthodontic treatment been rendered? Yes No
5. Does the patient suffer from any jaw joint problems such as pain, clicking, popping, etc.? Yes No
6. Have you ever observed your child has any habits? Thumb/finger sucking Mouth breathing Tongue thrust

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. Has the patient had any recent rapid growth? Yes No Early? Late? Females: Has menstruation begun? Yes No
If yes, when? _____ Pregnant? Yes No
6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Problems at Birth | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease/Murmur | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cleft Lip/Palate |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Speech or Hearing Problems |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Cancer/Radiation Therapy | <input type="checkbox"/> Tonsil, Adenoid, Sinus Problems |
| <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Emotional/Behavior Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> 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