

# WELCOME TO PISKLAK ORTHODONTICS

Dr. Carrie Pisklak • 6218-C Highway 6, Missouri City, TX 77459 • 281-403-5599

## PATIENT INFORMATION

Date: \_\_\_\_\_

This appointment for  Yourself  Your child

Patient Full Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female School: \_\_\_\_\_ Grade: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Who is accompanying the child today: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child: Yes No Other siblings/ages: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## RESPONSIBLE PARTY

Who is responsible for account: \_\_\_\_\_ Parent's Marital Status  Single  Married  Widowed  Divorced  Separated

Father  Step Father  Guardian

Mother  Step Mother  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address (if different) \_\_\_\_\_ Address (if different) \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

SS# \_\_\_\_\_ DL # \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_

Hm # \_\_\_\_\_ Cell # \_\_\_\_\_ Hm # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## INSURANCE INFORMATION

Dental Coverage  Yes  No

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## DENTAL HISTORY

Dentist: \_\_\_\_\_ Date of last cleaning: \_\_\_\_/\_\_\_\_/\_\_\_\_

Why have you come to the orthodontist today? \_\_\_\_\_

**CIRCLE** Yes or No to the following for the patient being seen today:

Yes No Have you/your child ever been evaluated or had orthodontic treatment before? If yes, when? \_\_\_\_\_

Yes No Have there been any injuries to the face, mouth, teeth or chin? Describe: \_\_\_\_\_

Yes No Do you/your child require antibiotics before dental treatment?

Yes No Have adenoids or tonsils been removed?

Yes No Have you/your child ever had difficulties associated with previous dental work?

Yes No Are you aware of any "gum" problems?

Yes No Do you/your child's gums bleed when brushing?

Yes No Do you/your child's teeth or jaws ever feel uncomfortable when waking in the morning?

Yes No Do you/your child experience any jaw clicking or popping?

**Yes No** Do you/your child currently have or have had any of the following: (If yes, please circle)

Clenching/Grinding teeth

Nail biting

Mouth breather

Lip sucking/biting

Thumb/finger sucking

Tongue thrust

Speech problems

Used pacifier

