WELCOME TO PISKLAK ORTHODONTICS

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

PATIENT INFORMATION — CHILD FORM — Date: _____

Patient Full Name: _____ Phone: (____) _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: ____/____/____ Age: _____ □ Male □ Female School: _____ Grade: _____

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

Name: _____ Birthdate: _____

Address (if different) _____

Email _____

SS# _____ DL # _____

Hm # _____ Cell # _____

Employer: _____ Occupation: _____

□ **Mother** □ Step Mother □ Guardian

Name: _____ Birthdate: _____

Address (If different) _____

Email _____

SS# _____ DL# _____

Hm # _____ Cell # _____

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 Has 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 Does your child require antibiotics before dental treatment?

Yes No Have adenoids or tonsils been removed?

Yes No Has your child ever had difficulties associated with previous dental work?

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

Yes No Does your child's gums bleed when brushing?

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

Yes No Does your child experience any jaw clicking or popping?

Yes **No** Does 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

MEDICAL HISTORY

Physician's Name: _____ Phone (_____) _____

CIRCLE Yes or No to following questions (If yes, please fill in details):

Yes No Do you consider your child in good medical health?
Yes No Is your child taking any medications? _____
Yes No Is your child **allergic** to any medications or dental products? _____
Yes No Does your child have a history of a major illness? _____
Yes No Has your child had any major operations? _____
Yes No Has your child begun puberty?
Yes No (Female patients only) Has your child begun menstruation?
Yes No (Female patients only) Is your child currently pregnant?

Yes **No** Does your child currently have or have had any of the medical conditions below : (If yes, please circle)

Abnormal bleeding	Diabetes	Hemophilia	Prosthetic joint/s
ADD/ADHD	Epilepsy	Hepatitis	Rheumatic Fever
AIDS/HIV+	Frequent headaches	Herpes/Fever blisters	Scarlet Fever
Arthritis	Handicaps/Disabilities	High blood pressure	Seizures/Fainting
Artificial bones/joints/valves	Hay fever	Kidney problems	Shingles
Asthma	Hearing impairment	Liver problems	Sickle cell disease/traits
Cancer	Heart attack/Stroke	Low blood pressure	Tuberculosis (TB)
Congenital heart defect	Heart murmur	Mitral valve prolapse	Venereal disease
Convulsions	Heart Surgery/Pacemaker	Nervous disorder	Other: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my/my child's status. I authorize the dental staff to perform the necessary dental/orthodontic services I/my child may need.
This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fee and may, at the discretion of this office, use the services of one or more credit reporting services.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent or Guardian **Date**

FOR OFFICE USE ONLY

PISKLAK ORTHODONTICS, PA
Carrie W. Pisklak, D.D.S., M.S.

I have been given the opportunity to receive the copy of this office's **NOTICE OF PRIVACY PRACTICES** which advises on how health information may be used and disclosed by **Pisklak Orthodontics, PA** and how I may obtain access to, and to control this information.

IF YOU WISH TO OBTAIN A COPY OF THIS INFORMATION, PLEASE SEE THE FRONT DESK

_____ _____

PRINT NAME **PATIENT NAME**

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

DESCRIPTION OF PERSONAL REPRESENTATIVE AUTHORITY

Please list who you want to have access to you/your child's pertinent medical/dental information (ie:family member, spouse)

_____ _____

May we leave messages on the answering machine/voicemail? Yes_____ No_____

Preferred Method of Contact? Home# _____

Work# _____ Cell#_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained due to the following:

_____Individual refused to sign

_____Communication barrier prohibited obtaining acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other – (Please specify) _____