WELCOME TO PISKLAK ORTHODONTICS

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

PATIENT INFORMATION

ADULT FORM

Date: ______________

Patient Full Name: ______________________ Preferred Name: __________ Phone: (____) __________

Address: ______________________ City: __________ State: ______ Zip: __________

Birthdate: ____/____/____ Age: ______ □ Male □ Female Drivers License #: __________ Social Security #: __________

Employer: ______________________ Occupation: ______________________ Work Phone: (____) __________

Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated Other family members seen by us: __________

Spouse Name (if applicable): ______________________ Phone: (____) __________ SS#: __________

Address: ______________________ City: __________ State: ______ Zip: __________

Birthdate: ____/____/____ Spouse Employer: ______________________ Spouse Occupation: __________

Emergency contact: ______________________ Relation: __________ Phone: (____) __________

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

PERSON RESBONSIBLE FOR ACCOUNT (if other than yourself)

Name: ______________________ Relation: __________ Phone: (____) __________

SS#: __________ Employer: ______________________ Work phone: (____) __________ DL#: __________

Billing Address: ______________________ City: __________ State: ______ Zip: __________

INSURANCE INFORMATION

Dental Coverage □ Yes □ No

Policy Holder Name: ______________________ Relation: __________ Insured DOB: __________ Insured 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 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 require antibiotics before dental treatment?

Yes No Have adenoids or tonsils been removed?

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

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

Yes No Do your gums bleed when brushing?

Yes No Do your teeth or jaws ever feel uncomfortable when waking in the morning?

Yes No Do you experience any jaw clicking or popping?

Yes **No** Do you 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 yourself in good medical health?
Yes	No	Are you currently taking any medications? ______________________
Yes	No	Are you **allergic** to any medications or dental products? ______________________
Yes	No	Do you have a history of a major illness? ______________________
Yes	No	Have you had any major operations? ______________________
Yes	No	(Female patients only) Have you begun menstruation?
Yes	No	(Female patients only) Are you currently pregnant?

Yes **No** Do you 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.

____

Patient Signature **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) ____