

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: _____ Nickname: _____ Phone: (____) _____ SS#: _____

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

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

Occupation: _____ Employer: _____

Dentist: _____ Phone: (____) _____ Referred by: _____

Emergency contact: _____ Relation: _____ Phone: (____) _____

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 than above)

Address (If different than above)

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

Why have you come to the orthodontist today? _____

Have you/your child ever been evaluated or had orthodontic treatment before? Yes No

Have you/your child seen a general dentist in the last 6 months? Yes No

Have there been any injuries to the face, mouth, teeth or chin? 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

Have you/your child ever had any pain/tenderness in your jaw joint (TMJ/TMD)? Yes No

Do you/your child brush/floss your teeth daily? Yes No

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

Do you/your child have any of the following habits?

Clenching/Grinding teeth Yes No

Nail biting Yes No

Thumb/finger sucking Yes No

Speech problems Yes No

Lip sucking/biting Yes No

Tongue thrust Yes No

Mouth breather Yes No

Used pacifier Yes No

Parent/Guardian Signature _____ Date _____

