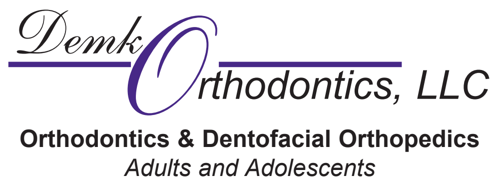
Jacqueline Anne Demko D.D.S., M.S.



Orthodontics & Dentofacial Orthopedics
Adults and Adolescents

☐ 14377 Woodlake Drive #216
Chesterfield, Missouri 63017
(314) 576-4955

☐ 2745 West Clay, Suite G
St. Charles, Missouri 63301
(636) 946-6503

☐ 904 S. Jefferson Street
Washington, Missouri 63090
(636) 239-2272

PATIENT INFORMATION

Date______________________________

Patient's Full Name____ Prefers to be called____________________
First, Middle, Last

Patient's Address____ Home Phone (   ) ____________________
Street City State Zip

Patient's Birthday________/________/________ Age__________ ☐ Male ☐ Female Favorite Hobbies ____________________
Month Day Year

Patient's Dentist____ School____________________
Name, City, State, Phone No.

Whom may we thank for referring you?______________________________ Other family members seen by us____________________

Name(s) and age(s) of siblings____E-mail____________________

RESPONSIBLE PARTY INFORMATION

Name______________________________ ☐ Married ☐ Single ☐ Divorced Home Phone (   ) ____________________
First, Middle, Last

Home Address____ No. of years at address ____________
Street City State Zip

Your relationship to patient______________________ D.L. No.__________________ Your Birthday________/________/________
Month Day Year

Your Employer____ Social Security No.__________/__________/__________

Your Occupation______________________________ Work Phone (   ) __________________ No. of years employed __________

Spouse's Name____ Spouse's Birthday________/________/________
First, Middle, Last *Month Day Year*

Spouse's Employer____ Work Phone (   ) ____________________

Spouse's Occupation______________________ Social Security No.________/________/________ No. of years employed __________

INSURANCE INFORMATION

Primary Orthodontic Insurance

Insured Name______________________________

Social Security No.__________/__________/__________

Insurance Co. Name______________________________

Insurance Co. Address______________________________

Insurance Co. Phone No. ______________________________

Group No. (Plan, Local, or Policy No).____________________

Relationship to Patient ______________________________

Insured's Birthday __________/__________/__________
Month Day Year

Insured's Employer______________________________

I have been informed of the treatment plan. I authorize release of any information relating to this claim.

➤ ____
Signed (Patient, or Parent if minor) Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

➤ ____
Signed (Insured Person) Date

Secondary Orthodontic Insurance

Insured Name______________________________

Social Security No.__________/__________/__________

Insurance Co. Name______________________________

Insurance Co. Address______________________________

Insurance Co. Phone No. ______________________________

Group No. (Plan, Local, or Policy No).____________________

Relationship to Patient ______________________________

Insured's Birthday __________/__________/__________
Month Day Year

Insured's Employer______________________________

I have been informed of the treatment plan. I authorize release of any information relating to this claim.

➤ ____
Signed (Patient, or Parent if minor) Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

➤ ____
Signed (Insured Person) Date

HEALTH HISTORY

Medical History

Please check if patient has, or has had…

YES	NO	
☐	☐	Joint swelling or Arthritis
☐	☐	Bone Disorders
☐	☐	Heart Trouble
☐	☐	Diabetes
☐	☐	Rheumatic Fever
☐	☐	Hepatitis or Liver Problems
☐	☐	Emotional Problems
☐	☐	Tuberculosis
☐	☐	AIDS or HIV
☐	☐	Epilepsy
☐	☐	Prolonged Bleeding
☐	☐	Endocrine Problems
☐	☐	Tonsils removed? If yes, when?___________
☐	☐	Asthma? If so, what medication(s)_________
☐	☐	Adenoids removed? If yes, when?_________
☐	☐	Minor/Major Surgery? If yes, when?________
☐	☐	Are you currently taking medication?

Dental History

History Update __/__/20__

Please check if patient has, or has had…

YES	NO	
☐	☐	Any injuries to ☐ Face ☐ Mouth ☐ Teeth
☐	☐	Thumb, finger or lip sucking habit(s)? ☐ Continuing ☐ Discontinued
☐	☐	Mouth breathing when ☐ Asleep ☐ Awake
☐	☐	Any known missing permanent teeth?
☐	☐	Any known extra permanent teeth?
☐	☐	Any teeth removed by extraction? When?______________________
☐	☐	Is there a tongue thrust problem?
☐	☐	Any clenching or grinding of teeth? ☐ Day ☐ Night ☐ Both
☐	☐	Any pain, popping or locking on opening or closing jaw movement? (Circle)
☐	☐	Frequent headaches? If yes, headaches per week________ ☐ a.m. ☐ p.m.
☐	☐	Any muscle tenderness or stiffness in the jaw or neck? (Circle)
☐	☐	Any ringing sounds in the ear, or spells of dizziness? (Circle)
☐	☐	Any previous treatment for TMJ or jaw joint problems? If yes, explain________ ____
☐	☐	Has patient ever been evaluated or had any previous orthodontic treatment? If yes, complete transfer information below.

List any Medication____ List any Allergies____

PLEASE LIST YOUR CHIEF CONCERN(S) AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH________________________

____

To the best of my knowledge the above info is correct

Signature of Parent ______________________________ Signature of Orthodontist______________________________

Emergency Information

Name of nearest relative not living with you____

Complete Address____

Phone (   )______________________________

A credit check may be obtained from Credit Bureau.

TRANSFER INFORMATION

Previous Orthodontist ____ Last seen____________________

Address____

Street *City* *State* *Zip*

Treatment Started____ Estimated Treatment Time____________________

Records Requested________/_______/_______ by ☐ mail ☐ phone. Spoke with ______________________________

Month *Day* *Year*