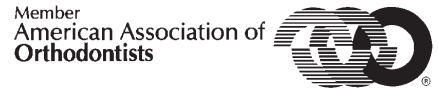




RONALD E. CLARK, D.M.D.
Children and Adult Orthodontics



Name _____ Date ____/____/____ Acct. No. _____

Nickname _____ Age _____ Birthdate ____/____/____ Sex: M____ F____

Street _____ Phone _____

City _____ State _____ Zip Code _____ Email _____

Referred By _____ Dentist _____

Father's Name _____ Birthdate ____/____/____ Soc. Security No. _____ - _____ - _____

Address _____ Phone _____

Employer/Occupation _____ Bus. Phone _____

Mother's Name _____ Birthdate ____/____/____ Soc. Security No. _____ - _____ - _____

Address _____ Phone _____

Employer _____ Bus. Phone _____

Names and Ages of Other Children in Family _____

Parents: Married Single Divorced Separated Widowed

Is patient in good health? _____ Yes No

Does patient have any history of major illness? _____ Yes No

Does your child need to be pre-medicated for dental procedures? _____ Yes No

Please list: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- | | | | | |
|--|--|---|--|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Liver Involvement | <input type="checkbox"/> Asthma |

Does patient have tendency to Colds Sore throats Ear Infections

Have tonsils and adenoids been removed? What age? _____ Yes No

Has the patient ever been exposed to HIV (AIDS) Virus? _____ Yes No

List any drugs or medications now being taken. Give reasons: _____

Does the patient have any special needs (physical, emotional, or mental)? _____ Yes No

If yes, please describe thoroughly so our office can better serve your child's needs _____

List any allergies or drug sensitivity: _____

Has the patient reached puberty? Girls – has she started menstruation _____ Yes No

Boys – has his voice changed _____ Yes No

Height _____ Weight _____

DENTAL HISTORY

Has there been any injuries to the face, mouth or teeth? _____ Yes No

Has the patient ever sucked a thumb or fingers? Until what age? _____ Yes No

Does the patient have any speech problems? _____ Yes No

Is the patient a mouth breather? While awake? _____ Yes No

While asleep? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Has either parent had orthodontic treatment? _____ Yes No

Reason for consultation _____

Dental Insurance Co. : Primary _____ Secondary _____

Parent's Signature (or Legal Guardian) _____