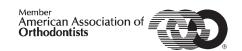


## RONALD E. CLARK, D.M.D.

Children and Adult Orthodontics



Name	Date// Acc	t. No	
Age Birthdate/ Sex: M F	Cell Phone		
Street			
City State Zip Code	Email		
Referred By De	entist		
Dental Insurance	Soc. Security No		
Insurance Address	Ins. Phone		
Employer/Occupation	Bus. Phone		
Spouse	Soc. Security No		
Dental Insurance	Birthdate	//	_
Insurance Address	Ins. Phone		
Is patient in good health?			No $\square$
Does patient have any history of major illness?		Yes $\square$	No 🗆
Do you need to be pre-medicated for dental procedures?		Yes $\square$	No 🗆
Please list:			
☐ Diabetes ☐ Bone Disorders ☐ Kidney Involvement ☐ Pneumonia ☐ Tuberculosis ☐ Endocrine Problems ☐ Heart Trouble ☐ Rheumatic Fever ☐ Prolonged Bleeding  Has the patient ever been exposed to HIV (AIDS) Virus?  List any drugs or medications now being taken. Give reasons:	<ul><li>☐ Fainting or Dizziness</li><li>☐ Nervous Disorders</li><li>☐ Liver Involvement</li></ul>	☐ Anemia ☐ Epileps ☐ Asthma	sy a No 🗆
Does the patient have any special needs (physical, emotional, or ment If yes, please describe thoroughly so our office can better serve your n	,	Yes	
yes, please describe thoroughly so our office can better serve your n	eeus		
List any allergies or drug sensitivity:			
DENTAL HISTORY	•		
Has there been any injuries to the face, mouth or teeth?  Has the patient ever sucked a thumb or fingers? Until what age?  Does the patient have any speech problems?  Is the patient a mouth breather?  While awake?  While asleep?  Have you been informed of any missing or extra permanent teeth?  Has an orthodontist been consulted previously?  Have you been treated previously?  Reason for consultation		Yes Yes Yes Yes Yes Yes Yes	No
0'			