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Date: _____

Adolescent/Child Patient Information

Full Name (Last, First, MI) _____ Nickname _____

Home Address _____ City/State/Zip _____

Cell/Home Phone _____ Date of Birth ____/____/____ Present Age _____ Gender _____

School/Employer _____ Grade _____

Patient's Residence Both Parents Father Mother Other _____

Siblings (age) _____ Favorite Hobbies _____

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

Family Dentist _____ Physician _____

Parent/Guardian Information

If parents are separated/divorced, please indicate the person who is financially responsible? _____

Who is the custodial parent? _____

Mother's Name: _____ Marital Status _____

Home Address _____

Social Security # _____ Date of Birth ____/____/____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Email address _____

Appointment reminders preference: Phone Email Text Wireless Carrier _____

Father's Name: _____ Marital Status _____

Home Address _____

Social Security # _____ Date of Birth ____/____/____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Email address _____

Appointment reminders preference: Phone Email Text Wireless Carrier _____

Dental/Orthodontic Insurance

Orthodontic insurance coverage? Yes No Don't know **Dual Coverage?** Yes No

Primary Insured's Name _____ Social Security # _____ Date of Birth ____/____/____

Insurance Company _____ Subscriber ID _____ Group Number _____

Secondary Insured's Name _____ Social Security # _____ Date of Birth _____

Insurance Company _____ Subscriber ID _____ Group Number ____/____/____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

Name of nearest relative not living with you _____ Phone _____

MEDICAL HEALTH HISTORY

In the following questions, circle yes or no whichever applies. Your answers are for our records only and will be considered confidential. **IF NECESSARY, PLEASE EXPLAIN ALL POSITIVE RESPONSES BELOW.**

- | | | |
|--|-----|----|
| 1. Are you under the care of a physician? | Yes | No |
| If so, when was your last visit and the condition being treated?
_____ | | |
| 2. Have you had any serious illnesses, accidents or operations? | Yes | No |
| If so, please explain: _____ | | |
| 3. Do you have or have you ever had any of the following diseases or problems? | | |
| a. Rheumatic fever or rheumatic heart disease? | Yes | No |
| b. Congenital heart defects? Heart murmur? Heart disease? | Yes | No |
| c. Artificial Heart Valve(s)? Artificial Joint(s)? | Yes | No |
| d. Asthma or hayfever? | Yes | No |
| e. Dizzy spells or seizures? | Yes | No |
| f. Diabetes? | Yes | No |
| g. Hepatitis, jaundice or liver disease? | Yes | No |
| h. Arthritis? Inflammatory rheumatism (painful, swollen joints)? | Yes | No |
| i. Kidney trouble? | Yes | No |
| j. Tuberculosis? | Yes | No |
| k. Thyroid problems? | Yes | No |
| l. Venereal disease? AIDS or AIDS related disease? | Yes | No |
| m. Frequent headaches? <input type="checkbox"/> AM <input type="checkbox"/> PM | Yes | No |
| n. Do you currently use tobacco or have a past history of tobacco use? | Yes | No |
| o. High or low blood pressure? | Yes | No |
| p. Chronic ear pain or infections? | Yes | No |
| q. Psychiatric counseling? | Yes | No |
| r. Anemia? Bleeding Disorder? | Yes | No |
| 4. Have you had surgery or x-ray treatment of a tumor, growth or other condition of your head or neck? | Yes | No |
| 5. Do you have any disease, condition or problem not listed above? | Yes | No |
| If so, explain _____ | | |
| 6. Have your tonsils or adenoids been removed? | Yes | No |
| 7. Are you taking any drugs or medicine? | Yes | No |
| If so, what? _____ | | |
| 8. Are you allergic or have you reacted adversely to any medication? | Yes | No |
| If so, what? _____ | | |
| 9. Has a physician told you to take antibiotics before dental procedures? (pre-medication). | Yes | No |
| 10. Are you able to breathe through your nose? | Yes | No |

FEMALES ONLY:

- | | | |
|--|-----|----|
| 11. Are you pregnant? | Yes | No |
| 12. Have you started your menstrual cycle? | Yes | No |

Patient's known allergies:

- | | | |
|-------------------------|-----|----|
| Latex | Yes | No |
| Metal/Jewelry | Yes | No |
| Plastics | Yes | No |
| Anesthetics | Yes | No |
| Penicillin | Yes | No |
| Erythromycin | Yes | No |
| OTHER | Yes | No |

Has the patient ever taken a **bisphosphonate medication** for a bone disorder or bone cancer such as: Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosto, Bonafos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa

	Yes	No
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Comments: _____

DENTAL HISTORY

1. Date of last dental cleaning: _____
2. Do you brush daily? Yes No How many times per day? _____
3. How often do you floss? _____
4. Are you aware of any of the following conditions?
 - a. Clenching or grinding your teeth? Yes No
If so, does it occur during the: Day Night
 - b. Any clicking, popping or locking of the jaw when opening or closing mouth? Yes No
With pain? Yes No For how long? _____
 - c. History of periodontal disease? Yes No
If so, have you undergone any periodontal treatment or surgery? Yes No
 - d. History of gingivitis (bleeding gums)? Yes No
 - e. History of blisters on lips/mouth? Yes No
5. Have you ever had orthodontic treatment or been treated for a bad bite? Yes No
6. Any previous treatment for TMJ or jaw joint problems? Yes No
If yes, explain: _____
7. Have you ever injured your face, jaw, mouth or teeth? Yes No
8. Have any baby or permanent teeth been removed by your dentist? Yes No
9. Any known missing or extra permanent teeth? Yes No
10. Have you had wisdom teeth removed? Yes No
11. Any thumb, finger, or lip sucking habit? Yes No
Is this habit: Active In the past Until what age? _____
12. Has an orthodontist been consulted previously? Yes No
If yes, reason: _____
13. Please list any family history of orthodontic treatment or jaw problems and name family relation:

14. Please list your main concern(s) and what you would like orthodontic treatment to accomplish:

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information and have answered all questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to the patient's health. I authorize Clark Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay direct to Clark Orthodontics including dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents. I authorize Clark Orthodontics to perform the necessary x-rays during initial and/or recall evaluations to assist in diagnosing proper treatment.

Patient's signature (or parent or guardian if patient is a minor)

Date