DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

RONALD E. CLARK, D.M.D.

Children and Adult Orthodontics

Member American Association of Orthodontists

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:

☐ Diabetes	☐ Bone Disorders	☐ Kidney Involvement	☐ Fainting or Dizziness	☐ Anemia
☐ Pneumonia	☐ Tuberculosis	☐ Endocrine Problems	☐ Nervous Disorders	☐ Epilepsy
☐ Heart Trouble	☐ Rheumatic Fever	☐ Prolonged Bleeding	☐ Liver Involvement	☐ 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) _____