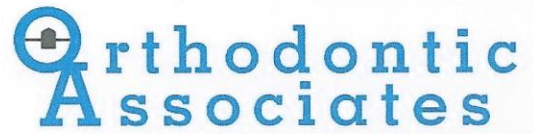


WELCOME



To assist us in providing the most comprehensive care, please provide the following personal information and health history.

R. Gordon Karker, D.M.D., P.C.

Thank you

PATIENT INFORMATION

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
First Middle Last

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month Day Year

Home address \_\_\_\_\_ Home phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

Employed by \_\_\_\_\_ Work phone \_\_\_\_\_

e-mail \_\_\_\_\_

SPOUSE/PARTNER

Dentist \_\_\_\_\_

Name \_\_\_\_\_

Physician \_\_\_\_\_

Employed by \_\_\_\_\_

Physician \_\_\_\_\_

Work Phone \_\_\_\_\_

Whom can we thank for referring you?  
\_\_\_\_\_

Mobile Phone \_\_\_\_\_

e-mail \_\_\_\_\_

What are your main concerns regarding your orthodontic condition? (overbite, crowding, function, esthetics, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Please describe your reasons for considering orthodontic treatment.

- Improved facial appearance
- Improved functional health
- Enhanced long-term dental health
- Other \_\_\_\_\_

\_\_\_\_\_

Please complete other side →

MEDICAL HISTORY

Do you have a history of any of the following?  
Check when yes

- Epilepsy
- Asthma
- Diabetes
- Blood Disorder
- HIV
- Hepatitis
- Heart problems, pacemaker
- Glaucoma
- Rheumatic Fever
- Frequent headaches
- Tonsil or adenoid removal
- Allergies (if yes, please list)

Are you?  
Check when yes

- In good Health
- Under a physician's care?  
If yes, for what condition?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Have you ever taken any of these osteoporosis medications?  
(Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

Please note any other factors the doctor should know about your health:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DENTAL HISTORY

- Bleeding gums
- Had permanent teeth removed
- Injury to face or teeth
- Night time teeth grinding
- Clicking or pain in jaws
- Chronic facial pain

- Recent dental Check up?  
Date: \_\_\_\_\_
- Previous periodontal evaluation?  
Date: \_\_\_\_\_  
By whom? \_\_\_\_\_

- Previous orthodontic treatment?  
Date: \_\_\_\_\_  
By Whom? \_\_\_\_\_
- Previous orthodontic evaluation?  
Date: \_\_\_\_\_  
By whom? \_\_\_\_\_

Please note any other factors the doctor should know about your dental health.

\_\_\_\_\_

\_\_\_\_\_

AUTHORIZATION

I authorize the release of medical and dental information to insurance carriers and to other health care providers involved in my care.

In the future please advise the doctor of any changes in your medical or dental health while under care in this office.

Signature \_\_\_\_\_

Date \_\_\_\_\_