WELCOME

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

Thank you

Orthodontic Associates

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

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*