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 _____ School _____ Grade _____

Dentist _____ Physician _____

Referred by _____ Was child adopted? _____

PARENT INFORMATION

Name _____ Name _____

Address _____ Address _____
If different

_____ _____

Home Phone _____ Home Phone _____

Mobile Phone _____ Mobile Phone _____

e-mail _____ e-mail _____

Employed by _____ Employed by _____

What are your main concerns regarding your child's 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 describe your child's attitude toward orthodontic treatment.

- ❑ Eager
- ❑ Complacent
- ❑ Antagonistic

Please complete other side →

MEDICAL HISTORY

Does your child 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)*

_____

_____

Is your child?
Check when yes

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

_____

_____

_____

Please note any other factors the doctor should know about your child's 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*