



Andrew E. Clark, DMD, MS
ORTHODONTIC PATIENT INFORMATION

Patient's Name: Age: Birthday: Sex:

Home Address: STREET CITY STATE ZIP CODE

Home Ph: Work Ph: Ext. Cell: SSN:

Person Responsible for Account:

Name: Relationship:

Home Address: STREET CITY STATE ZIP CODE

Home Phone: Work Ph: Ext. SSN:

E-Mail Address:

Employer: Occupation: Years Employed:

Spouse's Name:

Employer: Occupation: Years Employed:

SSN: Birthdate: Work Ph: Ext.

Patient lives with:

Other Family Members that have been seen by us:

Name and ages of brothers and sisters (if child):

Name and ages of children (if adult):

Dental Insurance Information:

Insured's Name: SSN:

Home Address: Work Ph: Ext. Home Ph:

Insurance Company: Employer: Group #:

Insurance Company Address:

Secondary Insurance?: Yes No If yes, complete the following:

Insured's Name: SSN:

Home Address: Home Ph:

Insurance Company: Employer: Group #:

Other Information:

Dentist: Physician:

School: Grade:

Have you ever been evaluated for Orthodontic Treatment?:

(Please complete the reverse side of this form)

Patient's Medical History

Have you been under the care of a physician in the past two years: _____

Have you ever had or do you now have any of the following:

Prolonged bleeding

Epilepsy

Diabetes

Heart problems

Rheumatic fever

Bone disorders

Tuberculosis

Hepatitis

AIDS or HIV

Cancer

Anemia

Asthma

Fainting or dizziness

Nervous disorder

Endocrine problems

Liver problems

Birth defects

Allergies

Have you had any surgery?

Yes No

Have you been hospitalized?

Yes No

List any medications you are now taking _____

Have you ever been told you need to take antibiotics before a dental procedure? Yes No

Patient's Dental History

Please check any of the following that apply:

Any family members who have had orthodontics

Teeth sensitive to hot or cold

Injuries to your face, jaw, mouth or teeth

Bleeding gums, bad taste in mouth

Root canals, crowns or bridges

Suck your thumb and/or fingers

Any clicking, popping or pain of the jaw or jaw joint (TMJ)

Any missing teeth or extra teeth

Trouble chewing

Date of more recent dental exam: _____

How often do you brush your teeth: _____

How often do you floss your teeth: _____

What is the main thing you would like to find out by coming to see Dr. Clark and what would you like to see done for your smile? _____

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

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to the medical/dental status, I will so inform this office. I understand that, in order to extend favorable financing to me, credit bureau reports may be obtained where appropriate.

Signature (Parent's signature if minor) _____ Date _____