CONFIDENTIAL

reflections

An Orthodontic Experience

SCOTT G. BLACKMAN DDS MS • GERALD R. KARR DDS MS

WELCOME TO OUR OFFICE.. We hope your visit will be pleasant.
To better serve you, we ask for the following information.

Personal Information

Patient's name

First Middle Last

Name you like to be called _____

Address _____
Street

City State Zip

Home Phone _____ Cell Phone _____

Age _____ Date of Birth _____ Sex _____

Ht. _____ Wt. _____ S.S.# _____

Preferred E-mail _____

Minors

Who is the custodial parent? ○ Mother ○ Father ○ Both

Who does the patient live with? ○ Mother ○ Father ○ Both

Father's Name _____

Mother's Name _____

School _____ Grade _____

Hobbies, Interests _____

Cell phones: Mother _____ Father _____

Insurance Information

Dental Insurance ○ Yes ○ No

Orthodontic Insurance ○ Yes ○ No

Primary Insurance Company _____

Secondary Insurance Company _____

Is either parent required by law to provide coverage? ○ Yes ○ No

If Yes, who? _____

Responsible Party Information

Name _____

Relationship to Patient _____

Social Security No. _____

Employer _____

Address(If different than patient's)

Street

City State Zip

Emergency Contact Information

Person to contact in case of emergency

Name _____ Phone _____

Health Care Provider Information

Dentist's name _____ Date of last exam _____

Reason for last visit _____

Dentist's office address _____ City _____ State _____ Zip _____

Physician's name _____ Date of last exam _____

Patient Profile

Check "Yes," "No" or "U" (unsure)

○ Yes ○ No ○ U Does patient follow directions well?

○ Yes ○ No ○ U Does patient brush his/her teeth conscientiously?

○ Yes ○ No ○ U Does patient have learning disabilities or need extra help with instructions?

○ Yes ○ No ○ U Is patient sensitive or self-conscious about teeth?

Females Only

○ Yes ○ No ○ U Has the patient started her monthly periods? When? _____

○ Yes ○ No ○ U Is the patient pregnant / nursing?

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Medical History

Now or in the past, has the patient had: If "Yes" explain below.

) Yes) No) U Birth defects / hereditary problems
) Yes) No) U Bone fractures / major accidents
) Yes) No) U Artificial joint replacement
) Yes) No) U Arthritis
) Yes) No) U Stomach ulcer / hyperacidity
) Yes) No) U Polio / mononucleosis / tuberculosis / pneumonia
) Yes) No) U Fainting spells / seizures / epilepsy / neurological disorders
) Yes) No) U Mental disorders / depression
) Yes) No) U Vision / hearing / speech difficulties
) Yes) No) U Recent weight / appetite loss
) Yes) No) U Eating disorder
) Yes) No) U Tired easily
) Yes) No) U Chest pains / shortness of breath
) Yes) No) U Asthma / hayfever / sinus problems
) Yes) No) U Anemia / blood disorders / hemophilia / AIDS / HIV positive
) Yes) No) U Kidney or liver disorders / hepatitis
) Yes) No) U Heart disease / heart valve disorders / murmurs
) Yes) No) U High blood pressure
) Yes) No) U Diabetes / thyroid disorders
) Yes) No) U Drug allergies / food allergies
) Yes) No) U Recent hospitalizations (last five years)
) Yes) No) U Tonsils / adenoids removed
When?_____
) Yes) No) U Significant change in weight recently?
) Yes) No) U Have you been told you can not donate blood? Why? _____
) Yes) No) U Radiation / surgery / chemotherapy for tumors
) Yes) No) U Antibiotic coverage for dental cleanings required
) Yes) No) U Frequent headaches / colds / sore throats
) Yes) No) U Ear / eye / nose / throat condition
) Yes) No) U Presently taking medication (List Below)

Allergies/Reactions

) Yes) No) U Novocaine / lidocaine
) Yes) No) U Aspirin
) Yes) No) U Ibuprofen
) Yes) No) U Penicillin / other antibiotics
) Yes) No) U Sulfa drugs
) Yes) No) U Codeine / other narcotics
) Yes) No) U Metals (clothing snaps / jewelry)
) Yes) No) U Latex (gloves / balloons)
) Yes) No) U Vinyl
) Yes) No) U Acrylic
) Yes) No) U Other substances (specify) _____

Dental History

) Yes) No) U Early / late teething
) Yes) No) U Baby teeth removed that were not loose
) Yes) No) U Permanent / extra teeth removed
) Yes) No) U Pain in teeth / gums
) Yes) No) U Thumb / finger sucking habit. Which?_____
) Yes) No) U Is Thumb / finger habit still present?
) Yes) No) U Grinding / clenching teeth
) Yes) No) U Speech problems / therapy
) Yes) No) U Breathing disorders / Tongue Thrust
) Yes) No) U History of trauma to teeth / jaw
) Yes) No) U Previous treatment of gum disease
) Yes) No) U Frightened by dental appointments
) Yes) No) U Recurring mouth / lip sores
) Yes) No) U Visit a dentist every six months
) Yes) No) U TMJ symptoms (discomfort in jaw joints)
) Yes) No) U Click / pop or pain in jaw joint
) Yes) No) U Do you brush daily?
) Yes) No) U Earaches
) Yes) No) U Headaches / facial pain
) Yes) No) U Previous TMJ / splint treatment
) Yes) No) U Previous orthodontic treatment
) Yes) No) U Currently wearing a retainer
) Yes) No) U Wisdom teeth have been removed
When _____

In this area list any medications you are taking and
Explain any "Yes" answers to questions above: _____

Patient's Concerns

Who suggested orthodontics for you? _____ What area of treatment concerns
Who recommended our practice to you? _____ you most?) Quality) Time) Cost

Please note

Our practice has two orthodontists. We believe a partnership practice provides the best care for most of our patients. Dr. Karr and Dr. Blackman mutually share the responsibility for the care of most patients. Both doctors will provide care if you do not specify otherwise.

I have read and understand the above questions. I will not hold Karr and Blackman or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical / dental status, I will inform this practice.

Patient signature_____ Date_____

Parent / guardian signature_____ Date_____

(for minors only)