

CONFIDENTIAL

KARR · BLACKMAN

orthodontics



designer smiles

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 _____ Work Phone _____

Age _____ Date of Birth _____ Sex _____

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

INSURANCE INFORMATION

Dental Insurance Yes No

Orthodontic Insurance Yes No

Primary Insurance Company _____

Secondary Insurance Company _____

RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Patient _____

Social Security No. _____

Employer _____

Address (If different than patient's) _____
Street

_____ City State Zip

MINORS

Does patient live with both parents? No Yes

If "No", Who does child live with? _____

Father's Name _____

Mother's Name _____

School _____ Grade _____

Hobbies, Interests _____

Work phones: Mother _____ Father _____

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?

GERALD R. KARR, DDS, MS



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SCOTT C. BLACKMAN, DDS, MS



HEALTH HISTORY

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)

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 you most? Quality Time Cost

Who recommended our practice to you? _____

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)

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 _____