

**Kristin D. Clark D.D.S., M.S., P.A.**

5503 John F. Kennedy Blvd.  
North Little Rock, AR 72116  
P (501)758-4112 F (501)758-4117

Date: \_\_\_\_\_

**Adolescent/Child Patient Information**

Full Name (Last, First, MI) \_\_\_\_\_ Nickname \_\_\_\_\_

Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Cell/Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Present Age \_\_\_\_\_ Gender \_\_\_\_\_

School/Employer \_\_\_\_\_ Grade \_\_\_\_\_

Patient's Residence  Both Parents  Father  Mother  Other \_\_\_\_\_

Siblings (age) \_\_\_\_\_ Favorite Hobbies \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Family Dentist \_\_\_\_\_ Physician \_\_\_\_\_

**Parent/Guardian Information**

If parents are separated/divorced, please indicate the person who is financially responsible? \_\_\_\_\_

Who is the custodial parent? \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Email address \_\_\_\_\_

Appointment reminders preference:  Phone  Email  Text Wireless Carrier \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Email address \_\_\_\_\_

Appointment reminders preference:  Phone  Email  Text Wireless Carrier \_\_\_\_\_

**Dental/Orthodontic Insurance**

**Orthodontic insurance coverage?**  Yes  No  Don't know **Dual Coverage?**  Yes  No

Primary Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Company \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Group Number \_\_\_\_/\_\_\_\_/\_\_\_\_

*PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)*

Name of nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL HEALTH HISTORY

In the following questions, circle yes or no whichever applies. Your answers are for our records only and will be considered confidential. **IF NECESSARY, PLEASE EXPLAIN ALL POSITIVE RESPONSES BELOW.**

- |  |     |    |
|--|-----|----|
| 1. Are you under the care of a physician? . . . . .  | Yes | No |
| If so, when was your last visit and the condition being treated?<br>_____  |     |    |
| 2. Have you had any serious illnesses, accidents or operations? . . . . .  | Yes | No |
| If so, please explain: _____   |     |    |
| 3. Do you have or have you ever had any of the following diseases or problems?                                   |     |    |
| a. Rheumatic fever or rheumatic heart disease? . . . . .   | Yes | No |
| b. Congenital heart defects? Heart murmur? Heart disease? . . . . .  | Yes | No |
| c. Artificial Heart Valve(s)? Artificial Joint(s)? . . . . .   | Yes | No |
| d. Asthma or hayfever? . . . . .   | Yes | No |
| e. Dizzy spells or seizures? . . . . .   | Yes | No |
| f. Diabetes? . . . . .   | Yes | No |
| g. Hepatitis, jaundice or liver disease? . . . . .   | Yes | No |
| h. Arthritis? Inflammatory rheumatism (painful, swollen joints)? . . . . .                                       | Yes | No |
| i. Kidney trouble? . . . . .   | Yes | No |
| j. Tuberculosis? . . . . .   | Yes | No |
| k. Thyroid problems? . . . . .   | Yes | No |
| l. Venereal disease? AIDS or AIDS related disease? . . . . .   | Yes | No |
| m. Frequent headaches? <input type="checkbox"/> AM <input type="checkbox"/> PM . . . . .                         | Yes | No |
| n. Do you currently use tobacco or have a past history of tobacco use? . . . . .                                 | Yes | No |
| o. High or low blood pressure? . . . . .   | Yes | No |
| p. Chronic ear pain or infections? . . . . .   | Yes | No |
| q. Psychiatric counseling? . . . . .   | Yes | No |
| r. Anemia? Bleeding Disorder? . . . . .  | Yes | No |
| 4. Have you had surgery or x-ray treatment of a tumor, growth or other condition of your head or neck? . . . . . | Yes | No |
| 5. Do you have any disease, condition or problem not listed above? . . . . .                                     | Yes | No |
| If so, explain _____   |     |    |
| 6. Have your tonsils or adenoids been removed? . . . . .   | Yes | No |
| 7. Are you taking any drugs or medicine? . . . . .   | Yes | No |
| If so, what? _____   |     |    |
| 8. Are you allergic or have you reacted adversely to any medication? . . . . .                                   | Yes | No |
| If so, what? _____   |     |    |
| 9. Has a physician told you to take antibiotics before dental procedures? (pre-medication). . . . .              | Yes | No |
| 10. Are you able to breathe through your nose? . . . . .   | Yes | No |

**FEMALES ONLY:**

- |  |     |    |
|--|-----|----|
| 11. Are you pregnant? . . . . .                      | Yes | No |
| 12. Have you started your menstrual cycle? . . . . . | Yes | No |

*Patient's known allergies:*

- |                         |     |    |
|-------------------------|-----|----|
| Latex . . . . .         | Yes | No |
| Metal/Jewelry . . . . . | Yes | No |
| Plastics . . . . .      | Yes | No |
| Anesthetics . . . . .   | Yes | No |
| Penicillin . . . . .    | Yes | No |
| Erythromycin . . . . .  | Yes | No |
| OTHER . . . . .         | Yes | No |

Has the patient ever taken a **bisphosphonate medication** for a bone disorder or bone cancer such as:  
 Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosto, Bonafos, Boniva, Didronel, Fosamax, Fosamax+D,  
 Reclast, Skelid, or Zometa . . . . . Yes No

Comments: \_\_\_\_\_

## DENTAL HISTORY

1. Date of last dental cleaning: \_\_\_\_\_
2. Do you brush daily?  Yes  No      How many times per day? \_\_\_\_\_
3. How often do you floss? \_\_\_\_\_
4. Are you aware of any of the following conditions?
  - a. Clenching or grinding your teeth? ..... Yes      No  
If so, does it occur during the:  Day  Night
  - b. Any clicking, popping or locking of the jaw when opening or closing mouth? ..... Yes      No  
With pain?  Yes  No      For how long? \_\_\_\_\_
  - c. History of periodontal disease? ..... Yes      No  
If so, have you undergone any periodontal treatment or surgery? ..... Yes      No
  - d. History of gingivitis (bleeding gums)? ..... Yes      No
  - e. History of blisters on lips/mouth? ..... Yes      No
5. Have you ever had orthodontic treatment or been treated for a bad bite? ..... Yes      No
6. Any previous treatment for TMJ or jaw joint problems? ..... Yes      No  
If yes, explain: \_\_\_\_\_
7. Have you ever injured your face, jaw, mouth or teeth? ..... Yes      No
8. Have any baby or permanent teeth been removed by your dentist? ..... Yes      No
9. Any known missing or extra permanent teeth? ..... Yes      No
10. Have you had wisdom teeth removed? ..... Yes      No
11. Any thumb, finger, or lip sucking habit? ..... Yes      No  
Is this habit:  Active  In the past      Until what age? \_\_\_\_\_
12. Has an orthodontist been consulted previously? ..... Yes      No  
If yes, reason: \_\_\_\_\_
13. Please list any family history of orthodontic treatment or jaw problems and name family relation:  
\_\_\_\_\_  
\_\_\_\_\_
14. Please list your main concern(s) and what you would like orthodontic treatment to accomplish:  
\_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information and have answered all questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to the patient's health. I authorize Clark Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay direct to Clark Orthodontics including dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents. I authorize Clark Orthodontics to perform the necessary x-rays during initial and/or recall evaluations to assist in diagnosing proper treatment.

\_\_\_\_\_  
Patient's signature (or parent or guardian if patient is a minor)

\_\_\_\_\_  
Date