Date: _____

PLEASE PRINT IN INK

Ken Ricks, DDS, MSD

5601 AUBURN STREET
SUITE B
BAKERSFIELD, CA 93306

(661) 432-7773

RicksFamilyOrtho.com

MEDICAL HISTORY

please check if patient has or has had the following:

- [ ] joint swelling
- [ ] bone disorders
- [ ] heart trouble
- [ ] mitral valve prolapse
- [ ] rheumatic trouble
- [ ] diabetes
- [ ] emotional problems
- [ ] brain injury
- [ ] kidney or liver involvement
- [ ] joint prosthesis

have you or any members of your family had:

- [Y] [N] rheumatoid arthritis?
- [Y] [N] lupus?
- [ ] tuberculosis
- [ ] anemia
- [ ] epilepsy (convulsions)
- [ ] prolonged bleeding
- [ ] faintness/dizziness
- [ ] tonsils removed
- [ ] adenoids removed
- [ ] sore throat
- [ ] tonsillitis
- [ ] earaches
- [ ] arthritis
- [ ] latex allergy
- [ ] thyroid problems

on items checked, please provide a more detailed description:

_____

_____

_____

is patient presently under physician care for any reason?

_____

name of primary physician _____

other _____

list any other serious illnesses

_____

adolescent females: has menstruation begun?

date month/year _____

approx. how much has the patient grown in the last year? _____

DENTAL HISTORY

please check if patient has or has had the following:

- [ ] any injuries to face, mouth, or teeth
- [ ] thumb, finger, or lip sucking
- [ ] more than average amount of tooth decay
- [ ] extra permanent teeth
- [ ] teeth removed by extraction
- [ ] difficulty in swallowing or chewing
- [ ] any pain or clicking when opening mouth
- [ ] is the patient adopted? at what age? _____
- [ ] previously consulted by another orthodontist
- [Y] [N] does the patient visit the dentist regularly?

date of last visit _____

on items checked, please provide a more detailed description:

_____

_____

list drugs or medications now being taken

_____

_____

_____

do you take any medications for osteoporosis? [Y] [N]

if yes, please list: _____

list any allergies

_____

what do you want to accomplish with orthodontic treatment?

_____

patient's attitude toward orthodontic treatment:

very motivated will cooperate if needed not motivated

Signature _____ Date _____

Date: _____

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PATIENT INFORMATION

last name	first name	nickname	ssn	sex	birth date	age

mailing address	city	state	zip	home #

school (if student)	grade	[ ]single [ ] divorced [ ] married [ ] widow	employer/occupation	work #

email	fax #	cell #

how did you hear about us?	name of dentist	date of last visit

related patients that are or have been under our care	names and ages of other children
1.	1.
2.	2.
3.	3.
4.	4.

PARENT INFORMATION (please complete if patient is a minor)

father's name	ssn

address		

city	state	zip

email	

home #	cell #

employer/occupation	work #

mother's name	ssn

address		

city	state	zip

email	

home #	cell #

employer/occupation	work #

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

name	relation to patient	employer/occupation

mailing address	city	state	zip	home #

work #	cell #	fax #	email

insurance company	contract number	group number	group member birth date

if divorce is involved, who is the custodial parent?	may patient information be released to the non-custodial parent? [ ] yes [ ] no