



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

PLEASE PRINT IN INK

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 \_\_\_\_\_



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**Ken Ricks, DDS, MSD**

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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	<input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> married <input type="checkbox"/> 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			mother's name			ssn		
address						address					
city			state	zip		city			state	zip	
email						email					
home #			cell #			home #			cell #		
employer/occupation				work #		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? <input type="checkbox"/> yes <input type="checkbox"/> no					