Rarrick Orthodontics
Orthodontic Specialist

Mark P. Rarrick, D.M.D.,M.S.

250 BUFORD AVENUE
GETTYSBURG, PENNSYLVANIA 17325
PH: 717-334-8158 FAX 717-334-8622

736 SOUTH POTOMAC STREET
WAYNESBORO, PENNSYLVANIA 17268
PH: 717-762-1161

Adult Patient Information

Today's Date: _____/_____/_____ Full Name: _____ Nickname: _____

Birthdate: _____/_____/_____ Age: _____ SS#: _____ ☐Male ☐Female

Home #: _____ Cell #: _____ Email: _____

Home Address: _____

Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Divorced ☐Separated

Employer: _____ Occupation: _____

Employer's Address: _____

Work #: _____ How long working there? _____

General Information

Whom may we thank for referring you? _____

Other family members seen by us? _____

General Dentist: _____ Last Visit: _____

Dentist's Phone #: _____

In the event of an emergency, is there someone other than your spouse who lives near you that we should contact?

Name: _____ Phone #: _____

Address: _____

Spouse Information

Name: _____ Birthdate: ____/____/____ SS#: _____

Address (If different than patient's): _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Occupation: _____

Financial & Orthodontic Insurance Information

Who is responsible for the account? (If someone other than self or spouse): _____

Address: _____ Employer: _____

Relation: _____ SS#: _____ Phone #: _____

Primary Insurance Co. Name: _____ Phone #: _____

Secondary Insurance Co. Name: _____ Phone #: _____

Medical History

Please describe your current physical health: ☐Good ☐Fair ☐Poor

Physician: _____ Phone #: _____ Date of Last Visit: _____

Are you taking any prescription/over-the-counter drugs? _____

For women: Are you using a prescribed method of birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Week# _____ Are you nursing? ☐Yes ☐No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Anemia	Y	N	Asthma/Arthritis
Y	N	Artificial Bones/Joints/Valves	Y	N	Diabetes	Y	N	Cancer/Chemotherapy
Y	N	Blood Transfusion	Y	N	Emphysema	Y	N	Drug/Alcohol Abuse
Y	N	Congenital Heart Defect	Y	N	Glaucoma	Y	N	Fever Blisters/Herpes
Y	N	Difficulty Breathing	Y	N	Hemophilia	Y	N	Epilepsy/Seizures/Fainting
Y	N	Heart Attack/Stroke	Y	N	Heart Murmur	Y	N	Heart Surgery/Pacemaker
Y	N	Hepatitis	Y	N	High/Low Blood Pressure	Y	N	HIV+/AIDS
Y	N	Hospitalized for any reason	Y	N	Kidney Problems	Y	N	Mitral Valve Prolapse
Y	N	Psychiatric Problems	Y	N	Radiation Treatment	Y	N	Rheumatic/Scarlet Fever
Y	N	Severe/Frequent Headaches	Y	N	Shingles	Y	N	Sickle Cell Disease/Traits
Y	N	Sinus Problems	Y	N	Tuberculosis	Y	N	Ulcers/Colitis

Please list any serious medical condition(s) that you have ever had: _____

_____

Please list any other drugs/materials that you are allergic to: _____

_____

Dental History

What are the main concerns you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthodontic treatment? ☐Yes ☐No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Your current dental health is: ☐Good ☐Fair ☐Poor Have you ever had an injury to your: ☐Mouth ☐Teeth ☐Chin

Do you like your smile? ☐Yes ☐No

Gums ever bleed? ☐Yes ☐No

Do you generally breathe through your mouth? ☐Yes ☐No If yes, check one: ☐While Awake ☐While Asleep

Do you have any missing or extra permanent teeth? ☐Yes ☐No

Have you ever taken Fosamax, or any bisphosphonate? ☐Yes ☐No

Have you ever taken Phen-Fen? ☐Yes ☐No

Do you smoke or use tobacco in any form? ☐Yes ☐No

I understand that the information I have given is correct and to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary orthodontic services that I may need during diagnosis and treatment with my informed consent.

Patient Signature: _____ Date: _____

OFFICE USE ONLY: *I have verbally reviewed the medical/dental information above with the patient named herein.*

Signature/Initials of Reviewer: _____ Date: _____