STARNES ORTHODONTICS

Patient Health History and Information Sheet

PLEASE FILL IN ALL AREAS THAT APPLY

First Appointment:

Nickname: ______ Email Address: ______ Cell Phone: ______

Patients Address: ______ Telephone: ______

Birthdate: ______ Age: ______ Sex: ______

Patients School or Employer: ______ Grade or Position: ______

Interest/Hobbies ______

Primary Parent

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Responsible Party: ______ Home Telephone: ______

Address: ______ Alternate Number: ______

Employer Name & Address: ______ Work Telephone: ______

Social Security Number: ______ Birthdate: / / Cell Phone: ______

Secondary Parent

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Responsible Party: ______ Home Telephone: ______

Address: ______ Alternate Number: ______

Employer Name & Address: ______ Work Telephone: ______

Social Security Number: ______ Birthdate: / / Cell Phone: ______

How Did You Hear About Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other Source: ______

Whom May We Thank For Referring You To Us? ______ Present Dentist: ______

Reason For Examination: ______

Circle Yes or No for which the patient has a history:

Aids/HIV	Y N	Chronic neck pain	Y N	Endocrine problems	Y N	Hepatitis	Y N	Mouth breathing	Y N	Speech problems	Y N
Allergies	Y N	Clicking of jaw	Y N	Emotional disorders	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	TMJ problems	Y N
Asthma	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Latex Allergy	Y N	Seizures	Y N	Tooth Grinding	Y N
										Tuberculosis	Y N

Any disease, problems, or allergies not mentioned above? ______

Current Medications? ______

Has an orthodontist been consulted previously? ______ Have you had previous orthodontic treatment? ______

Names of Brothers & Sisters: (children only) ______

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of Orthodontic Insurance: ______ Telephone: ______

Name of Policy Holder: ______ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Policy Holders Birthdate: ______ Policy Holders Social Security/Subscriber ID: ______

Signature: ______ Relationship To Patient: Mother ______ Date: ______

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments: Initials: ______ Date______