New Patient Health History

Patient Information

Patient Name_____ Male Female
Last First Middle

Address_____
Street City State Zip

Primary Phone_____ Cell Phone _____Birthdate_____

Email_____ Age_____

School _____Grade _____

Siblings and ages_____

Whom may we thank for referring you to our office? _____

Orthodontic Insurance Information

Do you have: ☐ Insurance ☐ Orthodontic Benefit *(i.e. Mayo Benefit)* ☐ Flex Plan ☐ None

Policy Holder's Name _____ Social Security #_____ Birthdate _____

Insurance Company Name _____and Address_____

Insurance Group Number_____ Subscriber ID _____

Responsible Party Information

Name_____Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Cell Phone_____ Home Phone_____ Work Phone_____

Email Address *(for appointment reminders)* _____

Birthdate_____ Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Spouse's Name_____Relationship to Patient_____
Last First Middle

Employer_____Occupation_____No. Years Employed_____

Birthdate_____ Work Phone_____

Patient Medical History

1. Is the patient in good general health at this time? □ Yes □ No
2. Is the patient under the care of a physician at this time? □ Yes □ No
3. Is the patient taking any medication(s)? □ Yes □ No
4. Is the patient allergic to any medications? □ Yes □ No
5. Has the patient had tonsils and adenoids removed? □ Yes □ No
6. Has the patient ever had serious injuries or been hospitalized? □ Yes □ No
7. Does the patient have any special problems not listed? □ Yes □ No
8. Has the patient ever been advised by a physician to take an antibiotic prior to any dental work? □ Yes □ No

Please discuss any items answered yes:

Patient Dental History

Patient's Dentist_____

Date of Last Visit_____

Have there been any injuries to the face, mouth or teeth? □ Yes □ No

If Yes, please explain_____

Has the patient had (past or present) any of the following habits:

Thumb or finger sucking □ Yes □ No
Grinding of teeth at night □ Yes □ No
Lip Biting □ Yes □ No
Mouth Breathing □ Yes □ No
Has an Orthodontist been consulted previously for this patient? □ Yes □ No
Has there been orthodontic treatment for other family members? □ Yes □ No
If Yes, treated by Dr. _____
Has the patient ever been treated for:
TMJ □ Yes □ No
"Bad Bite" □ Yes □ No
Periodontal Gum Disease □ Yes □ No
Does the patient have any speech problems? □ Yes □ No
Is the patient concerned or anxious about orthodontic treatment? □ Yes □ No

Please explain any concerns about the appearance of the teeth and anything you would like to change about the smile:

Has the Patient ever had any of the following?

Yes	No		Yes	No	
□	□	Congenital Heart Defect	□	□	Inflammatory Rheumatism
□	□	Heart Disease	□	□	Arthritis
□	□	Hearing Impairment	□	□	Diabetes
□	□	Heart Murmur	□	□	Ulcers
□	□	Rheumatic Fever	□	□	Stroke
□	□	Prosthetic (Artificial) Joint	□	□	Anemia
□	□	Radiation Therapy	□	□	Asthma
□	□	Respiratory/Lung Disease	□	□	Epilepsy
□	□	High Blood Pressure	□	□	Glaucoma
□	□	Low Blood Pressure	□	□	Fainting Spells
□	□	Hepatitis			
□	□	Tuberculosis	□	□	Kidney Trouble
□	□	Aids or H.I.V. Positive	□	□	Liver Disease
□	□	Venereal Disease	□	□	Psychiatric Treatment
□	□	Herpes (oral cold-sores)	□	□	Drug Addiction
□	□	Blood Disorders	□	□	Headaches
□	□	Jaw Clicking	□	□	Earaches
□	□	Jaw Pain	□	□	Allergies
□	□	Emotional Issues	□	□	Tonsillitis
□	□	Latex Allergy	□	□	Other

PLEASE DISCUSS ANY ITEMS ANSWERED YES:

Bisphosphonates

Yes □ No □

Are you currently taking OR have you *ever* taken a Bisphosphonate medication, commonly used for Osteoperosis and other conditions that feature bone fragility? Bisphosphonates are sometimes marketed as Boniva, Fosamax, Fosamax+D, Actonel, Reclast, Actonel+Ca, Aredia, Didronel, Skelid, and Zometa.

If yes, when did you begin the medication? _____

When did you end the medication? _____

Acknowledgement

Benefits of Orthodontics include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay, decalcification, and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I understand that my diagnostic records and my name may be used for educational purposes. I also understand that orthodontic appointments are often during work and/or school hours. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. Starnes Orthodontics will not be held responsible for any problems arising out of inadequate or undisclosed information. In addition, I authorize Dr. Starnes to perform a complete orthodontic evaluation.

_____ _____

Signature of Patient or Patient's Legal Guardian, if a minor Date

- Please check here if you do NOT want a diagnostic X-Ray taken ☐

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Doctor's comments