

**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/HI V	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: \_\_\_\_\_

Mother  Father  Step Parent  Self  Other (specify) \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holders Birthdate: \_\_\_\_\_ Policy Holders Social Security/Subscriber ID: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship To Patient: <sup>Mother</sup> \_\_\_\_\_ Date: \_\_\_\_\_

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

Doctor's Comments: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_