# Welcome!

Thomas M. Stark, D.D.S., M.S.D. ORTHODONTIST

ACCOUNT # _____

## PATIENT INFORMATION

Date _____

Patient's Full Name: _____ Prefers to be called: _____
*First, Middle, Last*

Patient's Address: _____ Home Phone (_____) _____
*Street City State Zip*

Email address _____ Patient's Birthday ____/____/____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced
*Month Day Year*

Patient's Dentist _____ Date last visited _____

Whom may we thank for referring you? _____ Favority hobby _____

Other family members treated orthodontically: _____

Your Employer _____ Social Security No. ____/____/____

Your Occupation _____ Work Phone (_____) _____ No. of years employed _____

Spouse's Name _____ Spouse's Birthday ____/____/____
*First, Middle, Last* *Month Day Year*

Spouse's Employer _____ Social Security No. ____/____/____

Spouse's Occupation _____ Work Phone (_____) _____ No. of years employed _____

**PERSON RESPONSIBLE FOR ACCOUNT** (if other than above)

Name _____ Birthday ____/____/____ Social Security No. ____/____/____
*Month Day Year*

Address _____ Telephone (_____) _____
*Street City State Zip*

Employer _____ Occupation _____ No. of years employed _____

Orthodontic insurance coverage? ❑ Yes ❑ No Primary orthodontic insurance company name: _____

Secondary orthodontic insurance company name: _____

## HEALTH HISTORY

**Medical History**

Please check if patient has, or has had...

- ❑ Asthma. If so, what medication(s) _____
- ❑ Convulsions/Epilepsy
- ❑ Diabetes
- ❑ Heart Murmer/Congenital heart defect
- ❑ Hepatitis or Liver Problems
- ❑ HIV+ or AIDS
- ❑ Joint Swelling or Arthritis
- ❑ Operations/stays in hospital
- ❑ Prolonged Bleeding/Hemophilia
- ❑ Rheumatic Fever
- ❑ Tonsil/Adenoids Removed? If yes, when _____
- ❑ Tuberculosis ❑ Smoking

List any Allergies _____

Describe patient's current physical health: ❑ Good ❑ Fair ❑ Poor

**Dental History**

Please check if patient has, or has had...

- ❑ Any injuries to face, mouth, teeth or chin? (Circle)
- ❑ Thumb, finger or lip sucking habit(s)? ❑ Continuing ❑ Discontinued
- ❑ Mouth breathing when asleep, awake (Circle)
- ❑ Any known missing or extra permanent teeth?
- ❑ Any teeth removed by extraction? When _____
- ❑ Is there a tongue thrust problem?
- ❑ Any clenching or grinding of teeth? ❑ Day ❑ Night ❑ Both
- ❑ Any pain, popping or locking on opening or closing jaw movement? (Circle)
- ❑ Been evaluated or had previous orthodontic treatment?

Frequent headaches? If yes, headaches per week____ ❑ AM ❑ PM

Any muscle tenderness or stiffness in the jaw or neck? (Circle)

Any previous treatment for TMJ or jaw joint problems?

If yes, explain _____

PLEASE LIST YOUR CHIEF CONCERN(S) AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH: _____

_____

A credit check may be obtained from Credit Bureau. Signature: X _____