Welcome!

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

ACCOUNT # ____________

PATIENT INFORMATION

Date ____________

Patient's Full Name ____________ (First, Middle, Last) Prefers to be called: ____________

Patient's Address ____________ (Street, City, State, Zip) Home Phone (______) ____________

Patient's Birthday ___/___/___ (Month, Day, Year) Age ______ ❑ Male ❑ Female Favorite hobbies ____________

Patient's Dentist ____________ (Name, City, State) School ____________

Whom may we thank for referring you? ____________ Other family members treated orthodontically: ____________

RESPONSIBLE PARTY INFORMATION

Name ____________ (First, Middle, Last) ❑ Married ❑ Single ❑ Divorced Home Phone (______) ____________

Home Address ____________ (Street, City, State, Zip) E-mail address ____________

Your relationship to patient ____________ Your Birthday ___/___/___ (Month, Day, Year) Social Security No. ___/___/___

Your Employer ____________ Work Phone (______) ____________ No. of years employed ____________

Spouse's Name ____________ Spouse's Birthday ___/___/___ (Month, Day, Year)

Spouse's Employer ____________ Work Phone (______) ____________ Social Security No. ___/___/___

Orthodontic insurance coverage? ❑ Yes ❑ No

Primary Insured ____________ Insured's Employer ____________ Orthodontic Ins. Co. ____________

Secondary Insured ____________ Insured's Employer ____________ Orthodontic Ins. Co. ____________

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
- ❑ Operations/stays in hospital
- ❑ Prolonged Bleeding/Hemophilia
- ❑ Rheumatic Fever
- ❑ Smoking
- ❑ Tonsil/Adenoids Removed? If yes, when ____________
- ❑ Tuberculosis

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 ____________