Date _____

Welcome to Star Orthodontics

All information provided will remain confidential

PATIENT INFORMATION

Patient's Name _____ Legal Sex: ☐ Male ☐ Female
First Middle Last

Physical Address _____ Gender Identity: ☐ Male ☐ Female
Street City State Zip Code ☐ Non-binary

Mailing Address _____
(if different from above) Street / PO Box City State Zip Code

Phone _____ Cell _____ Email _____ Birthdate _____ Age ____ Social Security # _____

Employer _____ # of Years with company _____ Occupation _____

General Dentist _____ Primary Physician _____

Who May We Thank for Referring You to Our office? _____

PRIMARY RESPONSIBLE PARTY INFORMATION

Relationship To Patient ☐ Self ☐ Father ☐ Mother ☐ _____ Other - please explain

Name _____
First Middle Last

Marital Status: Single Married Divorced Widow(er)

Mailing Address _____
Street / PO Box

_____
City State Zip Code

How long at current address? _____ years _____ months

Previous Address _____
(if less than 3 years at current address) Street

_____
City State Zip Code

Phone: Home _____ Cell _____ Work _____

Social Security # _____ Birthdate _____

E-mail _____ Occupation _____

Employer _____ # of Years _____

SECONDARY RESPONSIBLE PARTY INFORMATION

Relationship To Patient ☐ Self ☐ Father ☐ Mother ☐ _____ Other - please explain

Name _____
First Middle Last

Marital Status: Single Married Divorced Widow(er)

Mailing Address _____
Street / PO Box

_____
City State Zip Code

How long at current address? _____ years _____ months

Previous Address _____
(if less than 3 years at current address) Street

_____
City State Zip Code

Phone: Home _____ Cell _____ Work _____

Social Security # _____ Birthdate _____

E-mail _____ Occupation _____

Employer _____ # of Years _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Policy Holder's Name _____

DOB _____ Social Security # _____

Insurance Company _____

Group # _____ ID # _____

Insurance Co. Phone _____

Secondary Dental Insurance

Policy Holder's Name _____

DOB _____ Social Security # _____

Insurance Company _____

Group # _____ ID # _____

Insurance Co. Phone _____

EMERGENCY CONTACT INFORMATION

Name of Nearest Relative not living with you _____ Relationship to Patient _____

Address _____ Phone _____
Street City State Zip Code

Sign Here _____

Signature of patient (18 or older) or parent / guardian (if patient is under 18)

Information Updates

Date	Initial
_____	_____
_____	_____

Welcome to STAR ORTHODONTICS

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PATIENT DENTAL HISTORY INFORMATION

Has the patient seen a dentist in the last 6 months?.....	Y	N
Date of last cleaning _____		
Any pain, clicking or discomfort in the ears?.....	Y	N
Any serious injury to the patient's mouth, face, teeth ?……..	Y	N
Have you been informed of missing or extra permanent teeth?.....	Y	N
Are you aware of any gum problems?.....	Y	N
Has a physician or dentist advised antibiotics before a dental exam?..	Y	N
Have the patient's tonsils or adenoids been removed?.....	Y	N
Has the patient been examined by an orthodontist before?.....	Y	N
If yes, when? _____		
Have other members of the family had orthodontic treatment?.....	Y	N
If yes, were you happy with the results?.....	Y	N

If no, why not?

_____

In your own words, what is the orthodontic problem?

_____

_____

What would you like orthodontic treatment to accomplish?

_____

_____

Is the patient / are you happy with his / her smile?.....	Y	N
Is the patient comfortable with the idea of wearing braces?.....	Y	N

Has the patient ever had the following habits?

Cheek, tongue or lip chewing?.....	Y	N
Sucks thumbs / fingers?.....	Y	N
Mouth breathing?.....	Y	N
Clenches teeth?.....	Y	N
Grinds teeth?.....	Y	N
Tongue thrusting?.....	Y	N
Speech Problems? ……	Y	N
Snores?.....	Y	N

PATIENT MEDICAL

Heart Disease?	Y	N	Hearing Problems?	Y	N
Heart Surgery?	Y	N	HIV Positive?	Y	N
Heart Murmur?	Y	N	AIDS?	Y	N
Rheumatic Fever?	Y	N	High Blood Pressure?	Y	N
Yellow Fever?	Y	N	Low Blood Pressure?	Y	N
Scarlet Fever?	Y	N	Tumors or Cancer?	Y	N
Rheumatism?	Y	N	Respiratory Disease?	Y	N
Arthritis?	Y	N	Measles/Mumps?	Y	N
Joint Replacement?	Y	N	Chicken Pox?	Y	N
Blood Disease?	Y	N	Polio?	Y	N
Liver Disease?	Y	N	Nervous/Emotional?	Y	N
Venereal Disease?	Y	N	Diabetes?	Y	N
Tuberculosis?	Y	N	Anemia?	Y	N
Thyroid Disease?	Y	N	Hemophilia?	Y	N
Kidney Disease?	Y	N	Emphysema?	Y	N
Fainting/Dizziness?	Y	N	Epilepsy?	Y	N
Stomach Disease?	Y	N	Blood Transfusions?	Y	N
Intestinal Disease?	Y	N	Asthma / Hay Fever?	Y	N
Bone Disease?	Y	N	Broken Bones?	Y	N
Endocrine Disease?	Y	N	Prolonged Bleeding?	Y	N
Mononucleosis?	Y	N	Yellow Jaundice?	Y	N
Hepatitis?	Y	N	Chemical Therapy?	Y	N
Fever Blisters?	Y	N	Radiation Therapy?	Y	N

Is the Patient:

Under Medical Care?.....	Y	N
Allergies?.....	Y	N
Please list_____		
Addicted to Drugs?.....	Y	N
Pregnant at this time?.....	Y	N
Currently Smoking?.....	Y	N
Normal Height / Weight?.....	Y	N

Taking Medication (s)? Y N Please list all medications:_____

_____

Has the patient had surgery? Y N Please list all surgeries: _____

Has the patient had a physical this year? Y N

Is there any social interaction disorder (ex: Autism, Aspergers) that we should be aware of in order to make the patient more comfortable? Y N

If yes, please explain: _____

Are you aware of any other disease, condition, or problem not listed above that we should know about? Y N

If yes, please explain:_____

Request of Release of Records

I, _____ hereby request and give my permission to Roxanne G. Robertson, D.D.S., M.S., P.C. to provide Dentists, Medical Doctors, and / or insurance with any and all information he / she may request with respect to the orthodontic care of _____. Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records. I acknowledge receipt of the Notice of Privacy Practices of this office.

Sign Here _____ Date _____

Signature of Patient (if 18 or older)

_____ Date _____

Signature of Parent, Legal Guardian or Custodian (if patient under 18)

OFFICE USE ONLY

Medical History Information Updates

I have reviewed the patient's dental and medical history and confirm that it is current and complete.

Signature of Patient or Parent, Legal Guardian or Custodian	Date
_____	_____
_____	_____
_____	_____