Kenneth E. Starling, Jr., D.D.S., PC

Orthodontics for Children, Teens, and Adults
131 Langley Drive, Suite A • Lawrenceville, Ga 30045 • (770) 963-8085 • Fax (770) 682-6951

Welcome to our office!

To assist us in providing the best care, please complete the following information and health history questionnaire. To complete on the computer you should be able to tab from field to field and enter the requested information. Then either print the form and bring it with you or email it to our office at info@drstarling.com. Thank you.

Personal Information

Date

Name

Home Address

Email

Social Security Number

Employed by

Occupation

Dentist

Physician

Whom may we thank for referring you?

Sex ◯ Male ◯ Female

Date of Birth

Home phone

Cell phone

Business Phone

Spouse's Information *(if applicable)*

Name

Email

Social Security Number

Employed by

Occupation

Home phone

Cell phone

Business Phone

What are your chief concerns regarding your orthodontic condition (overbite, crowding, etc.)?

Please describe your reasons for considering orthodontic treatment.

Medical History

Do you have any of the following?
Check when yes and explain as needed

- ☐ Abnormal bleeding/Hemophilia
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hayfever
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/ Aids
- ☐ Kidney problems
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or Cancer

- ☐ Are you taking any medication?
- ☐ Are you allergic to any medication?
- ☐ Do you have a history of a major illness?
- ☐ Have you had any major operations?
- ☐ Have you ever been involved in a serious accident?
- ☐ Are there any other medical conditions that we should be aware of?

Dental History

Check when yes and explain as needed

- ☐ Are you presently in any dental pain?
- ☐ Have there been any injuries to face, mouth or teeth?
- ☐ Do your gums bleed when you brush?
- ☐ Do you have any type of thumb or tongue habit?
- ☐ Are you a mouth breather?
- ☐ Would you object to wearing orthodontic appliances (braces) should they be indicated?
- ☐ Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
- ☐ Are you aware of your jaw clicking or popping?
- ☐ Are you aware of clenching your teeth during the day?
- ☐ Have you ever been told that you grind your teeth?
- ☐ Do you have headaches?
- ☐ Have you ever experienced chronic ringing in your ears?

If the patient is under age 16, height of parents? Mom Dad

Female Patients only:

Are you pregnant?

Have you ever seen an orthodontist? If yes, who and when?

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 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 also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Starling to perform a complete orthodontic evaluation.

Signature: _____Date: _____