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.

Date

Name
First *Middle* *Last*

Email

Whom may we thank for referring you?

Dentist

Preferred Name

Sex Male Female Age

Date of Birth

Home phone

Cell phone

Physician

Is the Patient adopted?

Mother or Guardian's Information *(if applicable)*

Name
First *Middle* *Last*

Home Address
Street
City *State* *Zipcode*

Employed by

Home phone

Cell phone

Business Phone

Email

Social Security Number

Father or Guardian's Information *(if applicable)*

Name
First *Middle* *Last*

Home Address
Street
City *State* *Zipcode*

Employed by

Home phone

Cell phone

Business Phone

Email

Social Security Number

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

Please describe your reasons for considering orthodontic treatment.

Medical History

Does your child have any of the following?
Check when yes.

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

Is your child taking any medication?
Is your child allergic to any medication?
Does your child have a history of a major illness?
Has your child had any major operations?
Has your child ever been involved in a serious accident?
Are there any other medical conditions that we should be aware of?

Dental History

Is your child presently in any dental pain?
Have there been any injuries to face, mouth or teeth?
Does your child's gums bleed when you brush?
Does your child have any type of thumb or tongue habit?
Is your child a mouth breather or snore?
Does your child's teeth or jaws ever feel uncomfortable
when they awake in the morning?
Are you aware of your child's jaw clicking or popping?
Are you aware of your child clenching their teeth?
Does your child have headaches?
Has your child ever experienced chronic ringing in their ears?
If the patient is under age 18, height of parents? Mom______ Dad______
Female Patients:
Are you pregnant? Expected delivery date.
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: __________________