Starr and Glick ORTHODONTICS
We make smiles

Welcome to Starr and Glick Orthodontics

We are excited to welcome you and your family to our practice! The benefits of a beautiful and healthy smile are immeasurable.
Please fill out this form completely so that we can provide you with the highest level of care.

1 Patient Information

Today's Date_____/_____/_____ ☐ Male ☐ Female

Name _____
LAST FIRST MI MR MRS MS DR

Nickname_____ SS #_____-_____-_____

Birthdate_____/_____/_____ Age _____

School_____ Grade _____

Home Address _____
STREET

_____
CITY STATE ZIP

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone # (_____)_____ Cell Phone # (_____) _____

Work Phone # (_____)_____

Email _____

Whom may we thank for referring you? _____

Names and ages of siblings _____

_____

Emergency Contact

Name _____

Relationship to Patient _____

Home Address _____
STREET

_____
CITY STATE ZIP

Best Phone (_____) _____

2 Responsible Party Information

Name _____
LAST FIRST MI

Relationship to Patient _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address_____

Previous Address (if less than 3yrs)

_____
STREET CITY STATE ZIP

Home Phone # (_____)_____ Cell Phone # (_____)_____

Work Phone # (_____)_____

Email _____

Birthdate_____/_____/_____ SS #_____-_____-_____

Occupation _____

Employer_____ No. Yrs Employed_____

Spouse's Name _____

Relationship to Patient _____

Spouse's Occupation _____

Spouse's Employer_____ No. Yrs Employed _____

Spouse's Birthdate____/____/_____ Spouse's SS #_____-_____-_____

3 Dental Insurance Information

Insured's Name _____ Relationship to the patient_____

Birthdate_____/_____/_____ SS #_____-_____-_____ Employer _____

Insurance Company _____

Insurance Co. Address _____ Phone (_____) _____

ID#_____ Group#_____ Local# _____

Is there dual coverage ☐ Yes ☐ No If yes, please continue

Insured's Name _____ Relationship to the patient_____

Birthdate_____/_____/_____ SS #_____-_____-_____ Employer _____

Insurance Company _____

Insurance Co. Address _____ Phone (_____) _____

ID#_____ Group#_____ Local# _____

16 Park Street
Medfield, MA 02052
(508) 359-2576

www.starrandglickorthodontics.com
info@starrandglickorthodontics.com

835 West Central Street
Franklin, MA 02038
(508) 528-8808

4 Medical History

Patient's Physician_____ Date of Last Visit_____/_____/_____

Physician's Address _____

Physician's Phone # (_____) _____

Patient's current physical health is ☐ Good ☐ Fair ☐ Poor

Is patient taking any prescription or over-the-counter drugs or medications ☐ Yes ☐ No

Please list each _____

Please indicate below if the patient has ever had any of the following medical problems.

Y N Abnormal Bleeding/Hemophilia
Y N ADD/ADHD
Y N Allergies to latex
Y N Allergies to metals/nickel (describe below)
Y N Allergies to plastic (describe below)
Y N Anemia
Y N Artificial Joints/Valves
Y N Arthritis
Y N Asthma
Y N Breathing Difficulty/Emphysema
Y N Blood Transfusion
Y N Cancer/Chemotherapy/Radiation Therapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Drug/Alcohol Addiction or Abuse
Y N Epilepsy/Seizures/Convulsions
Y N Fainting Spells
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any reason (describe below)
Y N Kidney Problems
Y N Liver Problems
Y N Mitral Valve Prolapse (MVP)
Y N Lupus
Y N Operations/Surgeries (describe below)
Y N Oral Fever Blisters/Herpes
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Disease/Trait
Y N Sinus Problems/Seasonal Allergies
Y N Tuberculosis (TB)
Y N Other:_____

FOR WOMEN:

Y N Is the patient pregnant?
Y N Is the patient nursing?

Please discuss any medical problems that the patient has had: _____

_____

Please list any allergies to any drugs, metals or plastics: _____

_____

Please share any information that you feel will be helpful for us to know in treating the patient: _____

_____

5 Dental History

Patient's Dentist_____ Date of Last Visit_____/_____/_____

What are the main concerns that brought the patient to our office? _____

_____

_____

_____

_____

Has the patient ever been evaluated for orthodontic treatment ☐ Yes ☐ No

If yes, when? _____

If yes, where? _____

Has the patient ever had significant problems with dental work? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

Has the patient ever had extractions? ☐ Yes ☐ No

When___/____/_____ Reason _____

Has the patient ever had periodontal (gum) treatment? ☐ Yes ☐ No

When___/____/_____ Describe treatment_____

_____

_____

_____

Has the patient ever experienced:

Clicking or popping sounds in the jaw ☐ Yes ☐ No

Locking of the jaw joint ☐ Yes ☐ No

Pain in the jaw joint or in front of the ear ☐ Yes ☐ No

Numbness or tingling in the mouth or face ☐ Yes ☐ No

Is there any history of clenching or grinding the teeth? ☐ Yes ☐ No

Is there any history of a speech problem? ☐ Yes ☐ No

Is there any history of a thumb/finger sucking habit? ☐ Yes ☐ No

6 Thank you for filling out this form

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services that the patient may need. This office reserves the right to verify the credit status of potential patients and/or responsible parties prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature_____Date_____/_____/_____

For Office Use Only

I have verbally reviewed the medical/dental information above with the patient/guardian named herein.

Comments _____ Signature_____Date_____/_____/_____

_____