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## Atlanta Orthodontic Specialists

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### WELCOME

To assist us in providing the most comprehensive care, please provide the following personal information and health history.

Thank you

Name \_\_\_\_\_  
*First Middle Last*

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
*Month Day Year*

Home address \_\_\_\_\_ Home phone \_\_\_\_\_

\_\_\_\_\_ Mobile phone \_\_\_\_\_

Employed by \_\_\_\_\_ Work phone \_\_\_\_\_

e-mail \_\_\_\_\_

### SPOUSE/PARTNER

Dentist \_\_\_\_\_ Name \_\_\_\_\_

Physician \_\_\_\_\_ Employed by \_\_\_\_\_

Whom can we thank for referring you? \_\_\_\_\_ Work phone \_\_\_\_\_

\_\_\_\_\_ Mobile phone \_\_\_\_\_

e-mail \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Please describe your reasons for considering orthodontic treatment:

\_\_\_\_\_ Improved long term dental health

\_\_\_\_\_ Improved smile esthetics

\_\_\_\_\_ Improved function

\_\_\_\_\_ Other

\_\_\_\_\_  
\_\_\_\_\_

Please complete other side →

## MEDICAL HISTORY

Do you have a history of any of the following?

Are you?

*Yes or no?*

*Check when yes*

\_\_\_\_\_ HIV

\_\_\_\_\_ In good health

\_\_\_\_\_ Asthma

\_\_\_\_\_ Under a physician's care?  
*If yes, for what condition?*

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Blood disorder

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Hepatitis

\_\_\_\_\_ Heart problems, pacemaker

\_\_\_\_\_ Glaucoma

\_\_\_\_\_ Rheumatic fever

\_\_\_\_\_ Frequent headaches

\_\_\_\_\_ Tonsil or adenoid removal

\_\_\_\_\_ Allergies (*if yes, please list*)

\_\_\_\_\_ Have you ever taken any of these osteoporosis medications?

(Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

Please note any other factors the doctor should know about your health:

## DENTAL HISTORY

\_\_\_\_\_ Bleeding gums

\_\_\_\_\_ Recent dental check-up?

\_\_\_\_\_ Previous orthodontic treatment?

\_\_\_\_\_ Had permanent teeth removed

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Injury to face or teeth

\_\_\_\_\_ Previous periodontal evaluation?

By whom? \_\_\_\_\_

\_\_\_\_\_ Night time teeth grinding

Date: \_\_\_\_\_

\_\_\_\_\_ Previous orthodontic evaluation?

\_\_\_\_\_ Clicking or pain in jaws

By whom? \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Chronic facial pain

By whom? \_\_\_\_\_

Please note any other factors the doctor should know about your dental health.

## AUTHORIZATION

Payment is appreciated at the time services are provided. We will be happy to assist with the preparation of insurance claim forms for your reimbursement.

I have read Atlanta Orthodontic Specialists' Notice of Privacy Practices.

In the future, please advise the doctor of any changes in your medical or dental health while under care in this office.

Signature

Date