



Patient Screening Sheet

Patient Name: _____

Patient Address: _____ Telephone: _____

Birthdate: _____ Age: _____ Sex: _____

Primary Responsible Party Mother Father Step Parent Self Other (specify) _____

Primary Responsible Party Name: _____ Cell Phone: _____

Home Address: _____ Home Telephone: _____

Work Telephone: _____ Email address: _____

Whom May We Thank For Referring You To Us? _____ Present Dentist: _____

I would like for Barakat Orthodontics to check my insurance benefits: yes no

Health History Questionnaire

Does the patient have or has ever had any of the following:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Periodontal problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Are you pregnant? (females) Due Date: _____	<input type="checkbox"/> craniofacial abnormalities
<input type="checkbox"/> ARC or AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Have you reached menopause?	<input type="checkbox"/> Had first menstrual cycle (females)
<input type="checkbox"/> Seizure	<input type="checkbox"/> Biphosphonate meds	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Other

I certify that the information on this form is correct. I have been offered access to **Notice of Privacy Practices** (HIPPA) policies. Written copies are available at my request. I authorize Barakat Orthodontics to discuss my medical information with the following people/list their relationship to me: (father, mother, step father, aunt..etc)

Name	Phone Number	Relationship to Patient

A \$35 fee may be charged for broken appointments or appointments cancelled with less than 24 hours notice

Signature: _____ Relationship To Patient: _____ Date: _____

Name (please print): _____