

Allyn M. Thames III, D.M.D., M.S. Phone: 334-501-7000 Fax: 334-501-7062

www.thamesorthodontics.com

Patient Information		
Address: Street City	Nickname: Age: Sex: Phone: Birthdate Home heral Dentist Last Visited	
Are there other family members who already see us?		
•	ble Party Information	
Address: Street City Home Phone: Cell Phone:	Social Security # Birthdate Number of years at current address: Email address: Work Phone: Years of employment:	
Address: Street City	Social Security # Birthdate Number of years at current address: Email address:	
Employer: Occupation:	Work Phone: Years of employment:	
•	Insurance SE HAVE YOUR CARD AVAILABLE FOR FRONT DESK CLERK Policy Holder's Name:	
Member/Contract/Policy ID #:		

Relationship to Patient:

Policy Holder's Social Security #: _____ - ____

General Information			
Patient's School	Brothers/Sisters (Include Ages)		
Patient's Hobbies			
Medical History			
Patient's Primary Concern for Orthodontic treatment:			
	ne: Last Visit:		
Is the patient in overall good general health? Yes No			
Has Puberty/Menstruation Begun? Yes No			
List any known medical conditions:			
List any medications now being taken, give reason:			
Is the patient allergic to any of the following? Aspirin Nickel Latex Penicillin Any Other Metals/Plastics Other Drug Allergies:			
Has a doctor/dentist ever told the patient that he/she should premed	icate with antibiotics before dental treatment? Yes No		
Dental History			
Has the patient's tonsils and/or adenoids been removed?	Yes No		
Has the patient had an orthodontist evaluation/treatment before?	Yes No		
Has the patient ever experienced jaw join pain/discomfort?	Yes No		
Has the patient ever had an injury to teeth/mouth/chin?	Yes No		
Has the patient been informed of missing or extra permanent teeth?	Yes No		
Does anyone in the patient's family have a similar dental condition's	? Yes No		
Does/Has the patient ever had any of the following habits? Lip Sucking/Biting Prolonged Bottle/Pacifier Mouth Breather Tongue Thrusting Thumb/Finger Sucking Speech Problems	Nail Biting Clenching/Grinding Teeth Other:		
To the best of my knowledge, the above information is complete and correct. It is my responsibility to inform this office of any changes in my child's medical status. I hereby give permission to Dr. Allyn M. Thames III, D.M.D, M.S. and his employees to provide orthodontic care to my child. I also give my permission for a panorex radiograph and a clinical examination. I have reviewed Thames Orthodontics, P.C.'s HIPAA Notice of Privacy Practices.			

Primary Responsible Party Signature: ______ Date: _____