



Allyn M. Thames III, D.M.D., M.S.

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www.thamesorthodontics.com

Adult Patient Information

Name: _____ First _____ Middle _____ Last **Age:** _____ **Sex:** _____

Address: _____ Street _____ city _____ zip **Phone:** _____ home _____ cell **Birthdate:** _____

Number of years at current address: _____ **Social Security#** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____ **Years of employment:** _____

General Dentist _____ **Last Visited** _____

Confirmation of your appointments: **E-mail** _____ **email address if yes:** _____

Text _____ **text number if yes:** _____

How did you hear about our office? _____

Are there other family members who already see us? _____

Spouse / Additional Contact Information

Name: _____ First _____ M _____ Last **Relationship to Patient:** _____ **Birthdate** _____

Address: _____ Street _____ City _____ Zip **Number of years at current address:** _____

Home Phone: _____ **Cell Phone:** _____ **Email address:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____ **Years of employment:** _____

Insurance

Do you have Orthodontic Insurance? _____ **PLEASE HAVE YOUR CARD AVAILABLE FOR FRONT DESK CLERK**

IF YES: **Primary Insurance Company:** _____ **Policy Holder's Name:** _____

Member/Contract/Policy ID #: _____ **Group #:** _____ **Birthdate:** _____

Policy Holder's Social Security #: _____ **Relationship to Patient:** _____

Medical History

Primary Concern for Orthodontic treatment: _____

Medical Physician: _____ Phone: _____ Last Visit: _____

Are you in overall good general health? _____

List any medications now being taken, give reason: _____

Has a doctor/dentist ever told you to pre-medicate with antibiotics before dental treatment? _____

Are you allergic to any of the following?

☐ Aspirin

☐ Nickel

☐ Latex

☐ Penicillin

☐ Any Other Metals/Plastics

☐ Other Drug Allergies: _____

Dental History

Have your tonsils and/or adenoids been removed? ☐ Yes ☐ No

Have you had an orthodontist evaluation/treatment before? ☐ Yes ☐ No

Have you experienced any jaw joint pain/discomfort? ☐ Yes ☐ No

Have you ever had an injury to teeth/mouth/chin? ☐ Yes ☐ No

Have you ever been informed of missing or extra permanent teeth? ☐ Yes ☐ No

Does anyone in your family have a similar dental condition? ☐ Yes ☐ No

Do/Have you ever had any of the following habits?

☐ Lip Sucking/Biting

☐ Clenching/Grinding Teeth

☐ Mouth Breather

☐ Nail Biting

☐ Tongue Thrusting

☐ Thumb/Finger Sucking

☐ Speech Problems

☐ 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 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 myself. 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:** _____