



Allyn M. Thames III, D.M.D., M.S.
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Child Patient Information

Name: _____ Nickname: _____ Age: _____ Sex: _____
First Middle Last
Address: _____ **Phone:** _____ **Birthdate** _____
Street City Zip
Social Security# _____ - _____ - _____ **Patient's General Dentist** _____ **Last Visited:** _____
Confirmation of your appointments: E-mail ____ Yes ____ No email address if yes: _____
Text ____ Yes ____ No text number if yes: _____
How did you hear about our office? ☐ Friend _____ ☐ Dentist Referral ☐ Online ☐ Phonebook ☐ Other _____
Are there other family members who already see us? _____

Responsible Party Information

Father

Name: _____ **Social Security #** _____ - _____ - _____ **Birthdate** _____
First M Last
Address: _____ **Number of years at current address:** _____
Street City Zip
Home Phone: _____ **Cell Phone:** _____ **Email address:** _____
Employer: _____ **Occupation:** _____ **Work Phone:** _____ **Years of employment:** _____

Mother

Name: _____ **Social Security #** _____ - _____ - _____ **Birthdate** _____
First M Last
Address: _____ **Number of years at current address:** _____
Street City Zip
Home Phone: _____ **Cell Phone:** _____ **Email address:** _____
Employer: _____ **Occupation:** _____ **Work Phone:** _____ **Years of employment:** _____

Insurance

Do you have Orthodontic Insurance? ☐ Yes ☐ No **PLEASE HAVE YOUR CARD AVAILABLE FOR FRONT DESK CLERK**

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

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

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

General Information

Patient's School _____

Brothers/Sisters
(Include Ages)

Patient's Hobbies

Patient's Primary Concern for Orthodontic treatment: _____

Primary Medical Physician: _____ Phone: _____ 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 pre-medicate with antibiotics before dental treatment? ☐ Yes ☐ No

Dental History

Have 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 joint 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? ☐ Yes ☐ No

Does/Has the patient ever had any of the following habits?

☐ Lip Sucking/Biting

☐ Prolonged Bottle/Pacifier

☐ Mouth Breather

☐ Nail Biting

☐ Clenching/Grinding Teeth

☐ 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 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: _____