Thomas Orthodontics BRIAN W. THOMAS, D.M.D., M.S., P.A.

PATIENT INFORMATION

Patient Name _____________________________________ Nickname__________ Middle Initial_______ Sex M/F

Birth Date ________/_______/______ SS#________-_____-________ Today's Date ________/_______/________

Address____ City __________________ ST____ Zip _______

Home Phone ___________________ Work Phone ____________________ Cell Phone ______________________

Occupation/School __________________________ Grade_______ Hobbies/Interest _________________________

Friend or Relative who is a Patient Here __________________________

Has the Patient Previously had an Orthodontic Consultation Before? Y / N Previous Orthodontic Treatment Y / N

Is so When / Where? ____ Dr.'s Name _____________________

What is it about your teeth / bite / appearance that ha brought you to see us? ________________________________

Who may we thank for referring you to our office? ____

RESPONSIBLE PARTY INFORMATION

Name ______________________________________ Relation to Patient ______________ Marital Status S/M/W/D

Address (If different)______________________________________ City ________________ ST____ Zip _______

Home Phone ___________________ Work Phone ____________________ Cell Phone ______________________

Birth Date ________/_______/______ SS#________-_____-________ DL # _______________________________

Employer _______________________ Occupation __________________________ Number of Years ___________

Insurance Company Name ______________________ Group Name_________________ Group # ______________

Spouse's Name _____________________________________ Relation to Patient ___________________________

Address (If different)_____________________________________ City _________________ ST____ Zip _______

Home Phone ___________________ Work Phone ____________________ Cell Phone ______________________

Birth Date ________/_______/______ SS#________-_____-________ DL # _______________________________

Employer _______________________ Occupation __________________________ Number of Years ___________

Insurance Company Name ______________________ Group Name_________________ Group # ______________

EMERGENCY INFORMATION

Name of nearest relative not living with you ________________________________

Address____ City __________________ ST____ Zip _______

Home Phone ___________________ Work Phone ____________________ Cell Phone ______________________

MEDICAL HISTORY

The following question should be answered about the patient being examined

Are you under the care of a medical doctor at the present time? If so, for what? ______________________________

____

Date and reason of your most recent visit to a physician ____

Are you allergic to any food, drug, or medicine? If so, what? _____________________________________

____

Are you taking any pills, drugs or medicines at this time? If so, what? ________________________________

____

Please check any of the following that you have or have had treatment for

	Yes	No	Year		Yes	No	Year
Adenoids Removed	☐	☐	____	HIV Positive	☐	☐	____
AIDS/HIV	☐	☐	____	Hyperactivity	☐	☐	____
Allergies	☐	☐	____	Kidney Disorder	☐	☐	____
Anemia	☐	☐	____	Liver Disorder	☐	☐	____
Blood Disorder	☐	☐	____	Lung Disorder	☐	☐	____
Bone Disease	☐	☐	____	Metal Allergy	☐	☐	____
Breathing Difficulties	☐	☐	____	Pregnancy (women)	☐	☐	____
Bronchitis	☐	☐	____	Prolonged Bleeding	☐	☐	____
Convulsions	☐	☐	____	Rheumatic Fever	☐	☐	____
Diabetes	☐	☐	____	Seizures	☐	☐	____
Emotional Disturbance	☐	☐	____	Speech Difficulties	☐	☐	____
Epilepsy	☐	☐	____	Stroke	☐	☐	____
Eye Disorders	☐	☐	____	Tonsils Removed	☐	☐	____
Fainting Spells	☐	☐	____	Tuberculosis	☐	☐	____
Heart Condition	☐	☐	____	Tumor or Cancer	☐	☐	____
Hepatitis	☐	☐	____	Venereal Disease	☐	☐	____
High Blood Pressure	☐	☐	____				

Other ____

Pleas Give Details ____

DENTAL HISTORY

Injuries to the face, mouth or teeth	Yes ☐	No ☐	Pain (ear, jaw joint, side of face)	Yes ☐	No ☐
Missing any permanent teeth	Yes ☐	No ☐	Difficulty in opening or closing the jaw	Yes ☐	No ☐
Previous Orthodontic treatment	Yes ☐	No ☐	Fingernail biting	Yes ☐	No ☐
Oral Surgery	Yes ☐	No ☐	Clench or grind your teeth at night	Yes ☐	No ☐
Periodontal Treatment	Yes ☐	No ☐	Cheek or lip biting	Yes ☐	No ☐
Bite adjustment or teeth ground down	Yes ☐	No ☐	Pencil biting	Yes ☐	No ☐
Worn a bite plate or other appliance	Yes ☐	No ☐	Mouth Breathing	Yes ☐	No ☐
TMJ disorder	Yes ☐	No ☐	Do you snore?	Yes ☐	No ☐
Clicking of the Jaw	Yes ☐	No ☐	Do you have Headaches?	Yes ☐	No ☐

Please give details ____

____

Reason for orthodontic exam ____

Please describe any previous orthodontic treatment ____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Thomas, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ Date __________________________