



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

Orthodontics for Children and Adults

Phone: 334-501-7000 Fax: 334-501-7062

www.thamesorthodontics.com

Personal Information

Patient's Full Name: _____ Nickname: _____ Age: ____ Sex: ____ Date of Birth: _____

Address: _____ Telephone: () _____ () _____
Street City Zip Home Cell

Number of years at current address: _____ Best telephone/cell number to call to confirm appointments: _____

Would you like E-mail confirmations for your appointments? YES No E-mail: _____

School: _____ Patient's Family Physician: _____

Patient's Family Dentist: _____ Date of Last Cleaning: _____

Please State your primary concern: _____

Are there other family members who already see us? _____

How did you hear about our office? Friend _____ Dentist Referral Online Phonebook Other _____

Person financially responsible for this account: _____ Telephone: _____

Father: _____ Employed By: _____ Occupation: _____ Yrs of Employment _____

Mother: _____ Employed By: _____ Occupation: _____ Yrs of Employment _____

Insurance

Do you have Orthodontic Insurance? Yes No Name of Insurance Company: _____

Do you have Medical Insurance? Yes No Name of Insurance Company: _____

Name of Primary Person on Card: _____ Age: ____ Gender: ____ Date of Birth: _____

Address: _____ Telephone: _____
Street City Zip Home Cell

Social Security Number: _____ - _____ - _____ Relationship to Patient: _____

PLEASE COMPLETE REVERSE SIDE

Emergency Information

Whom should we contact in the event of an emergency? _____

Address: _____ Best Telephone: () _____
Street City Zip

Medical History

Is the patient in overall good general health? Yes No

List any drugs or medications now being taken, give reason: _____

List any drug allergies (e.g. latex, penicillin, nickel, etc.): _____

Has a doctor/dentist ever told the patient that he/she should be premedicated with antibiotics before dental treatment? Yes No

Has the patient's tonsils and/or adenoids been removed? Yes No

Check Yes or No if the patient has a history of the following:

Autoimmune Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful Chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seasonal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting, Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date _____	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking of Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Tooth Grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sore	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cortisone Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Dental History

Has the patient had previous injuries to the face, mouth, or teeth? Yes No

Has the patient ever had pain or tenderness in the jaw joint (TMJ)? Yes No

Does anyone in the patient's family have a similar dental condition? Yes No

Does the patient have any speech difficulties? Yes No

Does the patient clench or grind his/her teeth? Yes No

Has the patient been informed of missing or extra permanent teeth? Yes No

Has an orthodontist been consulted previously? Yes No

Has the patient had previous orthodontic treatment? Yes No

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/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 myself/ my child. I also give my permission for a clinical examination. I have reviewed Thames Orthodontics, P.C.'s HIPAA Notice of Privacy Practices.

Primary Responsible Party Signature: _____ Date: _____