



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

Orthodontics for Children and Adults

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

Auburn Opelika Valley

www.thamesorthodontics.com

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

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

Best telephone/cell number to call to confirm appointments: _____

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

YES No **Text #:** _____

School: _____

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

Patient's Family Physician: _____

Whom may we thank for referring you to our office? _____

Are there other family members who already see us? _____

Please state your primary concern: _____

If responsible party is other than the patient, please provide information: Not Applicable

Primary Responsible Party: _____ **Age:** _____ **Sex:** _____ **Date of Birth:** _____

Marital Status: Single Married Divorced Widowed

Address: _____
Street City Zip

Home Telephone: _____ **Work Telephone:** _____ **E-mail:** _____

Social Security Number (For insurance purposes only): _____ - _____ - _____ **Relationship to Patient:** _____

Employer: _____ **Occupation:** _____ **Number of Years Employed:** _____

Person financially responsible for this account: _____

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

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

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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has the patient had previous tooth extractions or jaw surgeries? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has the patient ever had pain or tenderness in the jaw joint (TMJ)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone in the patient's family have a similar dental condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the patient have any speech difficulties? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the patient clench or grind his/her teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has the patient been informed of missing or extra permanent teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has an orthodontist been consulted previously? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has the patient had previous orthodontic treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Primary Responsible Party Signature: _____ **Date:** _____