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

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

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

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

Employer:_____ Occupation: _____Work Phone:_____ Years of employment:_____

General Dentist _____ Last Visited_____

E-mail for confirmation of your appointments _____

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

Are there other family members who already see us? _____

## Spouse / Additional Contact Information

**Name:** _____ _____ _____ Relationship to Patient: _____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 : _____ Policy Holder's Name: _____

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

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

**Please Complete Opposite Side**

## Medical History

Primary Concern for Orthodontic treatment:_____

Medical Physician: _____ Phone: _____ Last Visit: _____

Are you in overall good general health? Yes No

List any medications now being taken, give reason:_____

Has a doctor/dentist ever told you to pre-medicate with antibiotics before dental treatment? Yes No

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 join 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: _____ |

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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: _____**