THOMAS ORTHODONTICS

PRACTICE LIMITED TO ORTHODONTICS

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INITIAL CONSULTATION

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

PATIENT'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PATIENT'S PHONE _____ PATIENT'S CELL PHONE _____ EMAIL _____

PERSON RESPONSIBLE FOR THIS ACCOUNT(INSURED) _____

INSURED ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MOM'S CELL PHONE _____ DAD'S CELL PHONE _____ EMAIL _____

EMPLOYED BY _____ BUSINESS PHONE _____

IS THIS A SECOND OPINION? ☐ YES ☐ NO _____

REFERRED BY: DENTIST ☐ _____ PATIENT ☐ _____ OTHER ☐ _____

DENTAL HISTORY

DENTIST NAME: _____ PHONE: _____ CHIEF ORAL COMPLAINT: _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food Impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ T.M.J.
- ☐ Sinus problems
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth bleeding
- ☐ Thumb sucking
- ☐ Fingernail biting
- ☐ Gag reflex
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Bad breath
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ AGE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Blood transfusions
- ☐ Arthritis
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy
  If so, what month _____
- ☐ Venereal disease

THE ABOVE INFORMATION IS NEEDED IN CASE OF AN EMERGENCY

Dental insurance plan (if any) _____

Name of Carrier _____ Insured Date of Birth _____

Address _____ Phone _____

Subscriber ID _____ Group # _____ Amount of Ortho Coverage _____

INSURANCE: Please bring in your insurance form at the beginning of orthodontic treatment for a pre-treatment estimate. We will accept payment from insurance companies or directly from you. Please note that insurance rarely if ever covers your entire bill. Most insurance companies pay quarterly for braces. We will set up a payment plan with no interest charge at the initiation of treatment.

Signature _____ Date _____

(parent or guardian, if patient is a minor)