R. Sims Tompkins, D.M.D., P.A.

PRACTICE LIMITED TO ORTHODONTICS

PATIENT INFORMATION

PATIENT'S NAME: ______________________________ DATE: __________

HOME ADDRESS: ______________________________ PHONE (H): __________

______________________________ PHONE (C): __________

AGE: _______ DATE OF BIRTH: ____________________ SEX: _______

OCCUPATION: ____________________ EMPLOYER: ____________________

BUSINESS ADDRESS: ____________________ WORK PHONE: __________

SPOUSE'S NAME: ____________________ OCCUPATION: __________

EMPLOYER: ____________________ WORK PHONE: __________

BUSINESS ADDRESS: ____________________ CELL PHONE: __________

PERSON RESPONSIBLE FOR THIS ACCOUNT: ______________________________

RESPONSIBLE PARTY'S SOCIAL SECURITY NUMBER: ______________________________

ARE YOU COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT: YES / NO

(IF YES)

INSURANCE CARRIER: ____________________ POLICY #: __________

ADDRESS: ____________________ PHONE NUMBER: __________

____

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT: YES / NO

REFERRED BY: ______________________________

FAMILY DENTIST: ______________________________

FAMILY PHYSICIAN: ______________________________

MEDICAL / DENTAL HISTORY

_______ ARE YOU IN GOOD HEALTH?

_______ DO YOU HAVE A CURRENT MEDICAL PROBLEM?

_______ HAVE YOU BEEN UNDER A PHYSICIAN'S CARE DURING THE PAST TWO YEARS?
(OTHER THAN ROUTINE CHECK-UPS)

IF YES, WHAT IS THE REASON: ____

WOMEN:

-ARE YOU PREGNANT? ______ -ARE YOU NURSING? ________

-ARE YOU TAKING BISPHOSPHONATES? (FOSAMAX, ACTONEL, BONIVA, SKELID) ________

THE FOLLOWING DISEASES ARE OF INTEREST TO THE ORTHODONTIST
(PLEASE CIRCLE IF THE PATIENT HS HAD ANY OF THE FOLLOWING)

ALLERGIES PROLONGED BLEEDING TUBERCULOSIS BLOOD DISEASE ASTHMA COLDS

DIABETES FREQUENT SORE THROATS RICKETS HEPATITIS RHEUMATIC FEVER ANEMIA

BONE DISORDER EAR INFECTIONS NERVOUS HABITS HEART DISEASE JAUNDICE

FAINTING/DIZZINESS EMOTIONAL DISORDERS EPILEPSY ENDOCRINE PROBLEMS

DO YOU HAVE ANY SPECIAL HEALTH PROBLEM NOT LISTED ABOVE?

IF YES, PLEASE LIST: ____

PLEASE LIST THE MEDICATIONS THE PATIENT IS CURRENTLY TAKING: ____________________

DATE OF LAST DENTAL EXAM: ____________________

_______ HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? IS YES, EXPLAIN: ______________________________

_______ HAS THERE BEEN ANY INJURY TO YOUR FACE OR HEAD?

_______ ARE YOU INTERESTED IN HAVING YOUR TEETH STRAIGHTENED?

_______ HAS ORTHODONTIC TREATMENT BEEN SUGGESTED IN THE PAST?

_______ HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?

WHAT ARE YOU OR YOUR FAMILY DENTIST MOST CONCERNED ABOUT:

____

ADDITIONAL COMMENTS: ____