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

PRACTICE LIMITED TO ORTHODONTICS

PATIENT INFORMATION DATE: _____

PATIENT'S NAME: _____

HOME ADDRESS: _____

_____ HOME PHONE: _____

AGE: _____ DATE OF BIRTH: _____ SEX: _____

PATIENT'S SCHOOL: _____

FATHER'S NAME: _____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: _____

BUSINESS ADDRESS: _____ CELL PHONE: _____

MOTHER'S NAME: _____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: _____

BUSINESS ADDRESS: _____ CELL PHONE: _____

RESPONSIBLE PARTY: _____ SS# _____

ARE PARENTS: MARRIED _____ DIVORCED _____ WIDOWED _____

IS PATIENT ADOPTED: YES _____ NO _____

NUMBER OF CHILDREN IN FAMILY: _____

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT: YES / NO
(IF YES)

INSURANCE CARRIER: _____ POLICY #: _____

REFERRED BY: _____

FAMILY DENTIST: _____

MEDICAL / DENTAL HISTORY

_____ IS THE PATIENT IN GOOD HEALTH?

_____ HAS THE PATIENT REACHED PUBERTY?

_____ HOW MANY INCHES HS THE PATENT GROWN IN THE PAST 6 MONTHS?

_____ PATIENT'S HEIGHT _____ PATIENT'S WEIGHT

_____ FATHER'S HEIGHT _____ MOTHER'S HEIGHT

PATIENT'S DEVELOPMENT RESEMBLES FATHER / MOTHER / NEITHER

HAVE THE TONSILS AND/OR ADENOIDS BEEN REMOVED? YES / NO

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 EPILEPSY NERVOUS HABITS HEART DISEASE JAUNDICE

FAINTING/DIZZINESS EAR INFECTIONS EMOTIONAL DISORDERS ENDOCRINE PROBLEMS

DOES THE PATIENT 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: _____

_____ HAS THE PATIENT HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? IS YES, EXPLAIN: _____

_____ HAS THERE BEEN ANY INJURY TO THE FACE OR HEAD?

_____ IS THE PATIENT INTERESTED IN HAVING THE TEETH STRAIGHTENED?

_____ HAS ORTHODONTIC TREATMENT BEEN SUGGESTED IN THE PAST?

_____ HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?

_____ HAS ANY OTHER FAMILY MEMBER HAD ORTHODONTIC TREATMENT?

WHAT ARE YOU OR YOUR FAMILY DENTIST MOST CONCERNED ABOUT:

_____

ADDITIONAL COMMENTS: _____