KIDS & ADULTS

Doctor Tom's ORTHODONTICS

Tom Atkinson DMD, MS

Office: 864-329-1971

Thank you for your cooperation in filling out this form completely.

A B C

Patient Information

Date: _____ Sex: ☐ M ☐ F

Patient's Name: _____ Nickname: _____
Last First M Init.

Address: _____
Street City State Zip Code

Home #: _____ Cell #: _____ Age: _____ Date of Birth: _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____ ☐ Own ☐ Rent
Street City State Zip

How long at this Address _____ Previous Address (if less than 3 yrs.) _____
Street City State Zip

CONTACT INFORMATION: Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Social Security # _____ Birthdate _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Orthodontic Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec # _____

Primary Insurance Company _____ Group No. _____ Phone No. _____

Primary Insurance Co. Address _____

Insured's Employer _____

Do you have dual coverage? ☐ Yes ☐ No ***If yes:***

Secondary Insured's Name _____ Insured's Soc. Sec. # _____

Secondary Insurance Company _____ Group No. _____ Phone No. _____

Secondary Insurance Co. Address _____

Insured's Employer _____

Additional Patient Information

Name of current family dentist: _____ Date of last dental check-up: _____

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

IN CASE OF EMERGENCY:

Name of nearest relative not living with you _____ Phone _____

Complete Address _____

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (Parent's signature if patient is a minor) _____

Office Use Only

Updates: _____ Init. / Date _____ Init. / Date _____ Init. / Date _____ Init. / Date

Comments: _____

MEDICAL HISTORY

Has the patient ever had any of the following medical problems? Please circle Yes or No for each item.

Y	N	Heart disease/problems	Y	N	High/Low Blood Pressure
Y	N	Rheumatic fever	Y	N	Asthma / Difficult Breathing / Sinus Problems
Y	N	Abnormal bleeding	Y	N	Fever blisters / Ulcers
Y	N	Heart Murmur	Y	N	Venereal / Sexually Transmitted Disease
Y	N	Bone Disease (Problems in healing broken bones)	Y	N	Nervous / Emotional Problems
Y	N	Arthritis / Rheumatism	Y	N	Cancer / Tumor / Radiation or Chemotherapy
Y	N	Hepatitis	Y	N	Severe or Frequent Headache
Y	N	Shingles	Y	N	Hemophilia / Abnormal Bleeding / Anemia
Y	N	HIV / AIDS	Y	N	Kidney / Liver Problems
Y	N	Diabetes / Tuberculosis (TB)	Y	N	Drug or Alcohol Addiction
Y	N	Seizures / Epilepsy / Fainting Spells			

Teenagers: Has the patient reached puberty? Y N Has menstruation begun? (girls) Y N Females: Is there any possibility of pregnancy? Y N

Is the patient currently being treated by a physician? Y N Explain: _____

Are prescription / over-the-counter drugs being taken? Y N Please list: _____

The patient's current physical health is: ☐ Good ☐ Fair ☐ Poor

Please describe any medical condition / problem not listed above _____

Are there any allergies to any of the following:

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex	Y	N	Erythromycin	Other: _____			
Y	N	Any metal / plastic	Y	N	Aspirin	Y	N	Codeine	Y	N	Dental Anesthetics	_____			

Describe other allergies: _____

Y	N	Are you aware of any missing / extra adult teeth?	Y	N	Have the tonsils and /or adenoids been removed?
Y	N	Any past or present discomfort / clicking in the jaw joint? (TMJ)	Y	N	Has a physician or dentist advised taking antibiotics prior to dental procedures?
Y	N	Any past injuries to the: ☐ Mouth ☐ Teeth ☐ Chin			Please explain: _____

Do any of the following habits apply?

Y	N	Thumb / finger sucking	Y	N	Constant mouth breathing	Y	N	Lip / Cheek Biting
Y	N	Speech problems	Y	N	Clenching / Grinding Teeth	Y	N	Tongue Thrust swallow

The above information is correct to the best of my knowledge.

Signature (Parent's signature is patient is a minor) _____ Date _____

ORTHODONTIC INFORMATION

What would you like orthodontic treatment to accomplish? _____

Y N Has the patient ever been evaluated by an orthodontist or had orthodontic treatment before / currently?

-For those already in treatment, transferring orthodontic care to our office -

Your previous orthodontic provider was an: ☐ Orthodontist ☐ Family Dentist ☐ Pediatric Dentist

Previous Dr.'s Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Are your orthodontic records: With you? Y N Currently being shipped to us? Y N Still at the above Dr.'s office? Y N

FOR OFFICE USE

Medical History Reviewed: _____ / _____ Init. Date _____ / _____ Init. Date _____ / _____ Init. Date _____ / _____ Init. Date

Comments: _____

_____