KIDS & ADULTS

Tollison ORTHODONTICS

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: _____

_____