



TOMBLYN FAMILY ORTHODONTICS

CENTRAL AUSTIN | WESTLAKE | STEINER RANCH

Patient Name: _____ DOB: _____ Sex: M / F

Address: _____ City/ State/ Zip: _____

Email: _____ Cell Phone: _____

Whom may we thank for referring you: _____

Dental Insurance Information: (This may differ from your medical insurance.)

Name of Insurance Company: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Relationship to Patient: (Circle One) Parent/Guardian - Self - Partner/Spouse Gender: M / F

Member ID/SSN: _____ Group/Policy Number: _____

Name of Employer: _____ Insurance Phone #: _____

Dental History:

Dentist Name: _____ Date of last check-up: _____

Do you have any dental treatment to be completed? _____

Have you ever had any of the following dental concerns:

- ☐ Unfavorable experience with dental work
- ☐ Speech Problems
- ☐ Clenching and/or grinding
- ☐ Pain or clicking in the jaw
- ☐ Severe injury to the face or mouth
- ☐ Chipped tooth due to injury or accident
- ☐ Extractions of teeth (baby or permanent)

- ☐ Noticeable difficulty chewing/ swallowing
- ☐ Missing permanent teeth
- ☐ Extra permanent teeth
- ☐ Other:

What options are you interested in to straighten your teeth? (Circle all that apply)

Metal Braces

Clear Braces

Invisalign

Replace Retainers only

Continued on back →

Medical History:

Are you taking any prescription / over-the-counter drugs? _____

If so, please list each: _____

Have you ever had any of the following medical concerns? (Please check all that apply)

<ul style="list-style-type: none"><input type="checkbox"/> Anemia/ Bleeding disorder<input type="checkbox"/> Artificial bones, joints, valves<input type="checkbox"/> Blood transfusion<input type="checkbox"/> Cancer/ chemotherapy<input type="checkbox"/> Congenital heart defects<input type="checkbox"/> Diabetes<input type="checkbox"/> Pregnant (or possibility)<input type="checkbox"/> Behavioral/ Mental health	<ul style="list-style-type: none"><input type="checkbox"/> Asthma or Emphysema<input type="checkbox"/> Epilepsy / seizures<input type="checkbox"/> Fever blisters / Herpes<input type="checkbox"/> Glaucoma<input type="checkbox"/> Heart murmur / Pacemaker<input type="checkbox"/> High / Low blood pressure<input type="checkbox"/> HIV /AIDS<input type="checkbox"/> Kidney problems<input type="checkbox"/> Migraines / severe headaches	<ul style="list-style-type: none"><input type="checkbox"/> Shingles<input type="checkbox"/> Sickle Cell disease<input type="checkbox"/> Tuberculosis<input type="checkbox"/> Ulcers / Colitis<input type="checkbox"/> Other (please explain: _____ _____
---	---	--

Are there any other medical concerns that you would like us to be aware of?

Are you allergic to any of the following? (Please check all that apply)

<ul style="list-style-type: none"><input type="checkbox"/> Latex<input type="checkbox"/> Metals or Plastics<input type="checkbox"/> Codeine<input type="checkbox"/> Penicillin<input type="checkbox"/> Erythromycin	<ul style="list-style-type: none"><input type="checkbox"/> Dental Anesthetics<input type="checkbox"/> Aspirin<input type="checkbox"/> Tetracycline<input type="checkbox"/> Other (please indicate): _____
---	--

Emergency Contact:

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relationship: _____

Cell Phone: _____

Other Phone: _____

Thank you for filling out this form completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date