TOMBLYN FAMILY ORTHODONTICS
CENTRAL AUSTIN | WESTLAKE | STEINER RANCH

Patient Name: _____ Date of Birth: _____ Sex: F / M

(If differs from above) Nickname: _____

Patient Address: _____City/ State/ Zip: _____

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

Primary Parent/Guardian Contact Name: _____

Relation to Patient: _____ Date of Birth: _____

Email: _____ Cell Phone: _____

Address (if different): _____ City/State/Zip: _____

Marital Status: Single - Divorced/Separated - Widowed - Married – Spouse's Name: _____

Secondary Parent/ Guardian Contact Name: _____

Relation to Patient: _____ Date of Birth: _____

Email: _____ Cell Phone: _____

Address (if different): _____ City/State/Zip: _____

Marital Status: Single - Divorced/Separated - Widowed - Married – Spouse's Name: _____

Dental Insurance Information: (Please note, the dental provider may differ from your medical insurance.)

Name of Insurance Company: _____ Insurance Phone #: _____

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

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

Name of Employer: _____Member ID/SSN: _____

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

Has the patient ever had any of the following dental concerns:

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o Unfavorable experience with dental work o Speech Problems o Clenching and/or grinding o Pain or clicking in the jaw o Severe injury to the face or mouth o Chipped tooth due to injury or accident o Extractions of teeth (baby or permanent)	o Noticeable difficulty chewing/ swallowing o Missing permanent teeth o Extra permanent teeth o Other: _____ Does the patient have any dental treatment to be completed?_____

What options are you interested in to straighten the patient's teeth? (Circle all that apply)

Metal Braces Clear Braces Invisalign

Medical History:

Please list any prescription / over-the-counter medications your child is currently taking?

_____

Has your child ever had any of the following medical concerns? (Please check all that apply)

o Bleeding disorder o Anemia o Artificial bones, joints, valves o Blood transfusion o Cancer/ chemotherapy o Congenital heart defects o Diabetes o Drug Abuse o Behavioral/ Mental health	o Asthma or Emphysema o Epilepsy / seizures o Fever blisters / Herpes o Glaucoma o Heart murmur / Pacemaker o High / Low blood pressure o HIV /AIDS o Kidney problems o Migraines / severe headaches	o Shingles o Sickle Cell disease o Tuberculosis o Ulcers / Colitis o Other (please explain: _____ _____

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

_____

Is your child allergic to any of the following? (Please check all that apply)

o Latex o Metals or Plastics o Codeine .o Penicillin o Erythromycin	o Dental Anesthetics o Aspirin o Tetracycline o 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 Relation to Patient Date