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:

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: _____ _____

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)

o Anemia/ Bleeding disorder o Artificial bones, joints, valves o Blood transfusion o Cancer/ chemotherapy o Congenital heart defects o Diabetes o Pregnant (or possibility) 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?

_____

Are you 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 Date