NEW PATIENT INFORMATION FORM

Please fill out both sides of this form completely

PATIENT INFORMATION

Patient Name_____Date of Birth_____Age_____

Address_____City, State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Sex: Male **o** Female **o** Status: Married **o** Single **o** Child **o**

RESPONSIBLE PARTY INFORMATION

Name_____ Relationship to Patient_____

Home Phone_____ Cell Phone_____ Email_____

Address _____City, State_____Zip_____

Date of Birth_____ Employer_____Social Security #_____

Spouse's Name_____ Relationship to Patient_____

Home Phone_____ Cell Phone_____ Email_____

Address _____City, State_____Zip_____

Date of Birth_____ Employer_____ Social Security #_____

OTHER INFORMATION

Who will be bringing the patient to the appointments?_____

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

In case of emergency, please contact: Name_____Phone:_____

Address _____City, State_____Zip_____

INSURANCE INFORMATION

Primary Insurance Carrier_____Secondary Insurance Carrier_____

Primary Insurance Phone _____Secondary Insurance Phone_____

Primary Insured Name_____Secondary Insured Name_____

Primary Insured Birthdate_____Secondary Insured Birthdate_____

Primary Insured SS # or ID #_____Secondary Insured SS # or ID #_____

Primary Insured Employer_____Secondary Insured Employer_____

I give my permission for Thompson Orthodontics to contact my insurance company to determine plan benefits:

Signature_____Date_____

DENTAL HISTORY

General Dentist_____Phone_____

General Dentist Address_____City, State_____ Zip_____

Date of last dental exam_____

Please indicate whether the patient has had any of the following dental conditions:

Bleeding gums while brushing or flossing o Painful or sensitive teeth o Pain or noise in jaw joint o

MEDICAL HISTORY

Physician Name_____Phone_____

Have you been under the care of a physician during the last two years other than normal check ups?
Yes o No o

Please list previous surgeries_____

Please list any medications you are currently taking_____

Please list any medications you are allergic to_____

Do you have an allergy to latex?_____

Female Patients
Are you pregnant o Nursing o Taking birth control o

Please indicate which of the following conditions you now have or have had in the past:

ADD/ADHD	yes o	no o	High Blood Pressure	yes o	no o
Artificial Joints	yes o	no o	Kidney Disorder	yes o	no o
Asthma	yeso	no o	Liver Disease	yes o	no o
Autism	yes o	no o	Mitral Valve Prolapse	yes o	no o
Bleeding Disorder	yes o	no o	Radiation/Chemotherapy	yes o	no o
Cancer	yes o	no o	Rheumatic Fever	yes o	no o
Diabetes	yes o	no o	Stroke	yes o	no o
Epilepsy	yes o	no o	Thyroid Disorder	yes o	no o
Hay Fever	yes o	no o	Tuberculosis	yes o	no o
Heart Condition	yes o	no o	Ulcers/Stomach problems	yes o	no o
Hepatitis	yes o	no o	H.I.V. Positive (AIDS)	yes o	no o

Other(please list):_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Thompson, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____Date_____

Doctor Thompson Signature_____Date_____