



CARRIE H. THANGAMANI, DDS, MS

DATE _____

PATIENT

Name _____ Nickname that is preferred? _____
Birth date _____ Age _____ School _____
Address _____ City _____ Zip Code _____
Home Phone _____ (Cell) _____

FATHER

Name _____ Email Address _____
Address _____ Drivers License Number _____
Phone (Home) _____ (Work) _____ City _____ Zip Code _____
Employer's Name _____ Occupation _____ (Cell) _____
Employer's Address _____

MOTHER

Name _____ Email Address _____
Address _____ Drivers License Number _____
Phone (Home) _____ (Work) _____ City _____ Zip Code _____
Employer's Name _____ Occupation _____ (Cell) _____
Employer's Address _____

INSURANCE

Insurance Coverage Yes No Insurance Company _____ Group# _____
Insured's Name _____ Date of Birth _____ SS# _____

PARENTS' MARITAL STATUS

Married Divorced Separated Single Widowed

Who is the responsible party? _____
If Divorced, who is the custodial parent? _____
Indicate which parent should receive correspondence. **MOM** **DAD** **BOTH**

Family Dentist

Address _____ Phone Number _____
Date of last checkup _____

Family Physician

Address _____ Phone Number _____
Date of last checkup _____

How did you hear about our office? _____

Has this patient had previous orthodontic treatment? Yes No If Yes: Please give dates, provider, and type of treatment.

Has anyone else in your family received orthodontic care? _____

Are there any other siblings in the family? What are their ages? _____

What is your main concern about your child's teeth? _____

What are some of your child's hobbies and interests? _____

WHERE WOULD YOU LIKE US TO CONFIRM APPOINTMENTS?

Email _____ Home Phone _____ Cell _____ Text (please provide cell carrier) _____

PLEASE ANSWER HEALTH HISTORY QUESTIONS ON OTHER SIDE

Patient Name _____

Date _____

Yes No

	Yes	No
1. Are you under a doctor's care at the present time?		
2. Are you presently taking any medication regularly?		
3. Have you ever been told you have a heart condition (angina pectoris, heart murmur, etc.)?		
3a. Do you require any premedication before dental appointments?		
4. Have you ever been told that your blood pressure is too high or too low?		
5. Have you ever had rheumatic fever or rheumatic heart disease?		
6. Do you bleed excessively following a cut or other injury?		
7. Are you allergic to any food, drug, or medicine?		
8. Do you have other allergies such as hayfever or asthma?		
9. Have you ever been treated for diabetes?		
10. Have you ever been treated for epilepsy?		
11. Have you ever been diagnosed with or treated for ADD, ADHD, OCD, Bipolar Disorder, or any other behavioral or cognitive disorder?		
12. Have you ever taken Cortisone, ACTH, or other steroid drug?		
13. Have you ever had a blood disease?		
14. Have you ever had a bone disease, or more than one bone fracture?		
15. Have you ever had a tumor or cancer?		
16. Have you ever had surgery?		
17. Have you had your tonsils and adenoids removed?		
18. Have you ever had a disease of the eyes, ears, nose, nose, or throat?		
19. Have you had a recent weight gain or loss?		
20. Have you ever experienced prolonged bleeding following a tooth extraction or oral surgery?		
21. Have you ever experienced difficulty when dental anesthetics (Novocain) were administered?		
22. Have you been diagnosed with having AIDS or AIDS-Related Complex?		
23. Have you had any serious illness other than those mentioned?		
24. Have you had any accidents or injuries relating to your face, teeth, or head?		
25. Did you ever suck your thumb or fingers?		
26. Have you ever had any other oral habits (nail biting, lip biting, cheek biting, etc.)?		
27. Do you grind or clench your teeth?		
28. Did your primary ("baby") teeth erupt on time (6-9 months of age)?		
29. Has a dentist ever extracted any of your primary or permanent teeth?		
30. Did you have any physical or genetic anomalies at birth?		
31. Have you ever had:		
a. Pain in your jaw joint when opening, chewing, or yawning?		
b. Limited jaw movement?		
c. Clicking or popping noises in your ears while chewing?		
d. Your jaw get stuck open or closed?		
32. Do you play any sports regularly?		
33. Have you noticed any rapid growth in height recently?		
34. If any of the above questions are checked yes, please explain in the section below. Thank you!		

Parent's Signature _____