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Thomas M. Skafidas, DMD, PC

Atlanta Orthodontic Specialists

WELCOME

To assist us in providing the most comprehensive care, please provide the following personal information and health history.

Thank you

Name _____
First *Middle* *Last*

Sex _____ Age _____ Date of birth _____
Month *Day* *Year*

Home address _____ Home phone _____

_____ Mobile phone _____

Employed by _____ Work phone _____

e-mail _____

SPOUSE/PARTNER

Dentist _____ Name _____

Physician _____ Employed by _____

Whom can we thank for referring you? Work phone _____

_____ Mobile phone _____

e-mail _____

What are your chief concerns regarding your orthodontic condition? (overbite, crowding, function, esthetics, etc.)

_____

_____

Please describe your reasons for considering orthodontic treatment:

_____ Improved long term dental health

_____ Improved smile esthetics

_____ Improved function

_____ Other

_____

_____

Please complete other side →

MEDICAL HISTORY

Do you have a history of any of the following?

Yes or no?

_____ HIV

_____ Asthma

_____ Diabetes

_____ Blood disorder

_____ Epilepsy

_____ Hepatitis

_____ Heart problems, pacemaker

_____ Glaucoma

_____ Rheumatic fever

_____ Frequent headaches

_____ Tonsil or adenoid removal

_____ Allergies *(if yes, please list)*

_____

_____

Are you?

Check when yes

_____ In good health

_____ Under a physician's care?
If yes, for what condition?

_____

_____

_____

_____ Have you ever taken any of these osteoporosis medications?

(Actonel, Actonel+Ca, Aredia, Boniva,Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

Please note any other factors the doctor should know about your health:

_____

_____

_____

_____

DENTAL HISTORY

_____ Bleeding gums

____ Had permanent teeth removed

_____ Injury to face or teeth

_____ Night time teeth grinding

_____ Clicking or pain in jaws

_____ Chronic facial pain

_____Recent dental check-up?

Date: _____

_____Previous periodontal evaluation?

Date: _____

By whom? _____

_____Previous orthodontic treatment?

Date: _____

By whom? _____

_____Previous orthodontic evaluation?

Date: _____

By whom? _____

Please note any other factors the doctor should know about your dental health.

_____

_____

AUTHORIZATION

Payment is appreciated at the time services are provided. We will be happy to assist with the preparation of insurance claim forms for your reimbursement.

In the future, please advise the doctor of any changes in your medical or dental health while under care in this office.

I have read Atlanta Orthodontic Specialists' Notice of Privacy Practices.

Signature *Date*