JAMES W. TINNEMEYER, D.M.D.
PRACTICE LIMITED TO ORTHODONTICS

OK to leave message on answering machine Y_____N_____ Today's Date_____

Patient's name_____Age_____DOB_____Ht_____Wt_____

Address_____Zipcode_____Phone_____

*For Children/Adolescent

Father's name_____Mother's name_____

Employment: Father_____Phone_____

Mother_____Phone_____

Cell Phone_____

*For Adults

Employment_____Phone_____

Spouse's Name_____Employed By_____Phone_____

***Dental Insurance: Insurance Company**_____

Name of Policy

Holder_____**SS#ID#**_____

Date of Birth of Policy Holder_____**Group #**_____

*Regular Dentist_____Referred by_____

*Physician_____Address_____

Medical History:

*Does the patient have a history of any of the following? Please check if YES

Asthma_____ Hepatitis_____ Cerebral Palsy_____Allergies_____(Specify)

Diabetes_____ Bleeding Disorders_____ Arthritis_____ _____

Tuberculosis_____ Heart Disease_____ Kidney Disease_____ _____

Polio_____ Epilepsy_____ Lung Disease_____ _____

Rheumatic Fever_____ HIV Infection_____ Anemia_____ _____

Headaches_____ Respiratory Infections____ Liver Disease_____ _____

Heart Murmur_____If yes, does the patient require premedication prior to dental treatment? Specify_____

*Does the patient have any difficulty in breathing through the nose?_____

*The patient's general health?_____

*Any additional medical information, including any of the above_____

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*Is the patient allergic to any medication, ie an antibiotic, aspirin, etc. (Y)_____(N)_____Specify_____

*Is the patient presently under a doctor's care (Y)____(N)_____Physician's name and reason for treatment_____

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*Is the patient taking any medication (Y)_____(N)_____Specify_____

*For female patients: Has menstruation begun (Y)_____(N)_____Are you pregnant?_____

***Dental History:**

*Have any baby teeth been removed by your dentist (Y)_____(N)_____Were space maintainers places? (Y)_____(N)_____

Thumb sucking_____Blanket_____Sleeping Habits_____Finger Sucking_____ Lip Biting_____

Mouth breathing_____Muscle tics_____ Nail biting_____Tooth clenching/grinding_____

Tooth Sensitivity_____Speech disorder_____Does the patient receive speech therapy?_____

*Does the patient have any difficulty in chewing or swallowing food? (Y)_____(N)_____

*History of periodontal/gum disorders (Y)_____(N)_____Treatment?_____

*Does the patient have pain or clicking when opening or closing the mouth? (TMJ dysfunction) (Y)_____(N)_____

Who in the family has a similar dental condition?_____Orthodontic treatment?_____

General Information:

*School_____

*Is patient self conscious (Y)_____(N)_____Hobbies/Sports_____

*Is patient adopted? (Y)_____(N)_____Age(s) of sibling(s) Brothers_____Sisters_____