



**Orthodontics for Children & Adults** ♦

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*Welcome to Hilgers Orthodontics!* Your first visit to our office will be for a thorough examination by the Doctor to determine whether treatment is indicated at this time. There is No Fee for this initial evaluation. If treatment is needed at this time, full diagnostic records may be requested by the doctor. The X-rays and photos required are scheduled with Precision Dental Imaging next door to our office. We are excited to have you in our practice and look forward to treating your orthodontic needs!

**Please Complete the Following Form:**

**Is This Your First Time In Our Office?**  Yes  No

**Patient's Name** \_\_\_\_\_ Home Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex:  Male  Female

Home Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ School Name \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Social Security Number \_\_\_\_\_ Business Phone \_\_\_\_\_ Email \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_

Social Security Number \_\_\_\_\_ Business Phone \_\_\_\_\_ Email \_\_\_\_\_

**Who has legal custody of the patient?** \_\_\_\_\_

Number Of Other Children In The Family \_\_\_\_\_ Referred By \_\_\_\_\_

**Patient's Dentist** \_\_\_\_\_ **Date of Last Dental Cleaning/Exam** \_\_\_\_\_



Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Address \_\_\_\_\_

Does Your Child Have A Current Medical Problem? Yes  No  If So, What? \_\_\_\_\_

**Has Your Child Ever Had Any Of The Following?**

- |                               |  |                                   |  |
|-------------------------------|--|-----------------------------------|--|
| Heart Attack/Stroke           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Learning Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High/Low Blood Pressure       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Seizures/Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur/Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever               | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV+/Aids                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemophilia/Abnormal Bleeding  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery/Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Chemotherapy/Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Problems               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Bones/Joints           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus/Breathing Problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adenoids/Tonsils Removed      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| VD (Syphilis, gonorrhea)      | <input type="checkbox"/> Yes <input type="checkbox"/> No | ADHD                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Major Operations              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain/Pressure/Tightness in Chest  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any other medical conditions:

**Please Check All That Apply:**

- |                           |  |                                      |  |
|---------------------------|--|--------------------------------------|--|
| Pregnant                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Premature Birth                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| On a Prescribed Diet      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Using Dilantin or Equivalent         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Using Thyroid Drugs       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Using Hormones (incl. birth control) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Using Anxiety Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genetic Disorders                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list all other medications:

**Is Your Child Taking Medicines For:**

- |                                  |  |                           |  |
|----------------------------------|--|---------------------------|--|
| Diabetes (pills or shots)        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood (liver, iron pills) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nerves (tranquilizers/relaxants) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomache Trouble          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleeping                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart/Blood Pressure             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Are You Aware Of Any Allergies:**

- |                                    |  |                                     |  |
|------------------------------------|--|-------------------------------------|--|
| Aspirin/Codeine                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin/Tetracycline/Erthromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sulfa Drugs                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Antibiotics _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental Anesthetics (ex: Novacaine) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex/Rubber Gloves                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Metal/Nickel Allergies             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Emergency Information:**

Name Of Nearest Relative Not Living With You \_\_\_\_\_

Complete Address \_\_\_\_\_ Phone \_\_\_\_\_

What is the main reason for seeking orthodontic treatment? \_\_\_\_\_

Has your child had previous orthodontic treatment? If so, by whom? \_\_\_\_\_ Yes  No

Does your child have missing permanent teeth? If so, list \_\_\_\_\_ Yes  No

Does your child premedicate before their dental appointment? Yes  No

Does your child have difficulty swallowing? Yes  No

Do your child's gums bleed when they are brushed? Yes  No

Has your child ever been told they have "gum disease" or periodontitis? Yes  No

Has your child ever had professional instructions on dental home care? Yes  No

Is any part of your child's mouth sensitive to temperature or pressure? Yes  No

Does food catch between their teeth? Yes  No

Do they have any soreness around their eyes or ears? Yes  No

Do they have any unpleasant odor, or taste in their mouth? Yes  No

Are you or your child dissatisfied with the appearance of their teeth? Yes  No

Are they currently experiencing any pain? Yes  No

Have other family members had treatment in our office? Yes  No

**Do they have any of the following:**

Ringling in the ears Yes  No

Neck pain Yes  No

Back pain Yes  No

Headaches Yes  No

Dizziness Yes  No

Pain in teeth Yes  No

Face pain Yes  No

Jaw pain Yes  No

Grinding of teeth Yes  No

Popping/Clicking of Jaw Joint Yes  No

Have they ever been in an accident? Yes  No  Explain \_\_\_\_\_

Have they ever experienced a blow to the Jaw? Yes  No  Explain \_\_\_\_\_

Have they ever had an injury to their mouth/teeth/chin? Yes  No  Explain \_\_\_\_\_

Has their jaw joint ever locked or felt like it was sticking? Yes  No  Explain \_\_\_\_\_

Would you say their dental health is: Good  Fair  Poor

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. In addition, I will notify the doctor of any change in my (or my child's) health history.

Signature \_\_\_\_\_ Date \_\_\_\_\_