Orthodontics for Children & Adults ♦ Michael J. Hilgers DDS MS PC
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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_____ Date of Birth_____

Marital Status_____Social Security Number_____ Sex: ☐ Male ☐ Female

Home Address_____

City/State_____ Zip Code_____ Email_____

Home Phone_____ Cell_____ Fax_____

Employed By_____ Business Phone_____

Business Address_____

Occupation_____ Number Of Years Employed_____

Spouse's Name_____ Employed By_____

Business Address_____

Home Phone_____ Cell_____ Fax_____

Occupation_____ Number Of Years Employed_____ Business Phone_____

Number Of Children In The Family_____ Referred By_____

Patient's Dentist_____ **Date Of Last Dental Cleaning/Exam**_____

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a SMILE that's good for LIFE®

ADA American Dental Association®
ADA Recognized Specialty
Orthodontics And Dentofacial Orthopedics

ADULT FORM

Name of Physician_____ Phone_____ Date of Last Exam_____

Address_____

Do You Have A Current Medical Problem? Yes ☐ No ☐ If So, What?_____

Have You Ever Had Any Of The Following?

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

List any other medical conditions:

Are You Now:

Pregnant	☐ Yes ☐ No		Using Anticoagulents	☐ Yes ☐ No	
On a Prescribed Diet	☐ Yes ☐ No		Using Dilantin or Equivalent	☐ Yes ☐ No	
Using Thyroid Drugs	☐ Yes ☐ No		Using Hormones (incl. birth control)	☐ Yes ☐ No	
Taking Bisphosphonates *(Fosamax, Boniva, Actonel)*	☐ Yes ☐ No		Other Osteoporosis Medications	☐ Yes ☐ No	

Please list all other medications:

Are You Now Taking Or Using Medicines For:

Diabetes (pills or shots)	☐ Yes ☐ No		Blood (liver, iron pills)	☐ Yes ☐ No	
Nerves (tranquilizers/relaxants)	☐ Yes ☐ No		Stomache Trouble	☐ Yes ☐ No	
Sleeping	☐ Yes ☐ No		Headaches	☐ Yes ☐ No	
Heart/Blood Pressure	☐ Yes ☐ No		Allergies	☐ Yes ☐ No	

Are You Aware Of Any Allergies:

Aspirin/Codeine	☐ Yes ☐ No		Penicillin/Tetracycline/Erthromycin	☐ Yes ☐ No	
Sulfa Drugs	☐ Yes ☐ No		Other Antibiotics_____	☐ Yes ☐ No	
Dental Anesthetics (ex: Novacaine)	☐ Yes ☐ No		Latex/Rubber Gloves	☐ Yes ☐ No	
Metals/Nickel Allergies	☐ Yes ☐ No		Other_____	☐ Yes ☐ No	

Emergency Information:

Name Of Nearest Relative Not Living With You_____

Complete Address_____ Phone_____

What is the main reason for seeking orthodontic treatment?_____

Have you had orthodontic treatment? If so, by whom?_____ Yes ☐ No ☐

Do you have missing permanent teeth? If so, list_____ Yes ☐ No ☐

Do you premedicate before your dental appointment? Yes ☐ No ☐

Do you have difficulty swallowing? Yes ☐ No ☐

Do your gums bleed when you brush your teeth? Yes ☐ No ☐

Have you ever been told you have “gum disease” or periodontitis? Yes ☐ No ☐

Have you ever had professional instructions on dental home care? Yes ☐ No ☐

Is any part of your mouth sensitive to temperature or pressure? Yes ☐ No ☐

Does food catch between your teeth? Yes ☐ No ☐

Do you have any soreness around your eyes or ears? Yes ☐ No ☐

Do you have any unpleasant odor, or taste in your mouth? Yes ☐ No ☐

Are you dissatisfied with your teeth and their appearance? Yes ☐ No ☐

Are you currently experiencing any pain? Yes ☐ No ☐

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

Do you notice any of the following:

Ringing in the ears	Yes ☐ No ☐	Pain in teeth	Yes ☐ No ☐
Neck pain	Yes ☐ No ☐	Face pain	Yes ☐ No ☐
Back pain	Yes ☐ No ☐	Jaw pain	Yes ☐ No ☐
Headaches	Yes ☐ No ☐	Grinding of teeth	Yes ☐ No ☐
Dizziness	Yes ☐ No ☐	Popping/Clicking of Jaw Joint	Yes ☐ No ☐

Have you ever been in an accident? Yes ☐ No ☐ Explain_____
Has there ever been a blow to the Jaw? Yes ☐ No ☐ Explain_____
Have you ever had an injury to your mouth/ teeth/chin? Yes ☐ No ☐ Explain_____
Has your jaw joint ever locked or felt like it was sticking? Yes ☐ No ☐ Explain_____

Would you say your 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_____