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_____ 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**_____

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Orthodontics And Dentofacial Orthopedics

CHILD FORM

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	☐ 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	Congenital Heart Disease	☐ Yes	☐ No
VD (Syphilis, gonorrhea)	☐ Yes	☐ No	ADHD	☐ Yes	☐ No
Major Operations	☐ Yes	☐ No	Pain/Pressure/Tightness in Chest	☐ Yes	☐ No

List any other medical conditions:

Please Check All That Apply:

Pregnant	☐ Yes	☐ No	Premature Birth	☐ 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
Using Anxiety Medications	☐ Yes	☐ No	Genetic Disorders	☐ Yes	☐ No

Please list all other medications:

Is Your Child Taking 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
Metal/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?_____

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:

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 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_____