Adult New Patient Questionnaire and Health History: Hiller Orthodontics

Patient's name: _____Today's date: _____

Birth date: _____ /_____ /_____ Age: _____ **SSN**: _____-_____-_____

Home Address: _____
City: _____ Zip code: _____

Phone: (Home): _____ (Cell): _____ (Work): _____

*** **E-Mail**: _____

Other family members seen by Dr. Hiller: _____

Who may we thank for referring you to Dr. Hiller? _____

Name of Person financially responsible for this account: _____

Relationship to the patient: ____ Self ___ Spouse Other_____

Are you covered by Orthodontic Insurance? ___ Yes ___ No

Name of **Primary** Insurance carrier: _____
Insurance carrier's phone #: (_____) _____-_____
Policy Holder's Name: _____ **SSN**: _____-____-_____
Policy Holder's Date of Birth: ___ /___ /_____
Subscriber ID #: _____ Group#: _____

Policy holder's relationship to the patient: _____ Self _____ Spouse ___ Other _____
Policy Holder's Employer: _____

Name of your **General Dentist**: _____ Last visit:_____
Name of your **Physician**: _____ Last visit: _____

Are you currently under the care of a Physician? ___ Yes ___ No
Explain? _____

Are you taking any prescribed medications? ___ Yes ___ No
List all: _____

Have you ever had any of these following medical conditions? (circle if yes)

HIV/AIDS Asthma Artificial bones/joints/heart valves congenital heart defect bleeding problems

frequent headaches Heart murmur Heart attack Hepatitis A or B Mitral Valve Prolapse Ulcers

High Blood Pressure Radiation Therapy Anxiety Disorder ADHD/ADD Sleep Disorder

Please list any serious medical conditions that you have now or in the past: _____

_____

_____

Are you allergic to any of the following? (circle if yes)

Aspirin Codeine Penicillin Erythromycin Tetracycline Latex Metals Dental anesthetics

Other allergies: _____

For Women Only: Are you pregnant? ____Yes ____ No If yes, due date is _____

What are the main concerns about your teeth you would like orthodontic treatment to correct or improve?

_____

_____

Have you ever been treated with orthodontic braces? ___ Yes __ No

Have you ever experienced any of the following?

Popping or clicking noises in your jaw joints when chewing, eating, talking, or opening your mouth wide?
____ Yes ____ No

Pain or soreness in your lower jaw muscles or in front of your ears when chewing, talking, or opening your mouth wide?
____ Yes ____ No

Jaw muscle tightness and/or headaches upon awakening first thing in the morning? ____ Yes ____ No

Clenching, grinding, gritting, or gnashing your teeth together will awake or when asleep? ____ Yes ____ No

Have you ever been diagnosed or treated for TMJ or TMD? ____ Yes ____ No

Have you ever experienced an injury to your teeth, mouth, or chin? ____ Yes ____ No

Have you ever been in a car accident or job-related accident? ____ Yes ____ No

If Yes, explain: _____

Currently, do any of your teeth hurt, throb, or ache? ____ Yes ____ No
Currently, are any of your teeth sensitive to cold or hot? ____ Yes ___ No
Do your gums bleed when you brush your teeth? ____ Yes ____ No
Do you smoke or use smokeless tobacco? ____ Yes ____ No

I understand that the information that I have given today is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical /dental status. I authorize Dr. Hiller and his staff to perform any necessary dental/ orthodontic services that I may need during my diagnosis and treatment, with my informed consent. ___ ***Yes,*** *I agree with the above statement*

Name: _____ Date: _____

Reviewed by: _____ Date: _____

Doctor's Comments: