ORTHODONTIC ASSOCIATES

ADAM MILLER, D.D.S., LLC

DATE: _____

OFFICE: _____

ACCOUNT #: _____

PATIENT INFORMATION

Patient's Name: _____

Birth Date: _____ Age: _____ Sex: M ___ F ___

Home Address: _____

City/State: _____ Zip: _____

Primary Phone: _____

Business Phone: _____

Cell Phone: _____

Fax: _____

E-Mail: _____

Patient's Employer or School: _____

Number of Siblings: _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____

Relationship to Patient: _____

Home Address: _____

City/State: _____ Zip: _____

Primary Phone: _____

Business Phone: _____

Cell Phone: _____

Fax: _____

E-Mail: _____

Employer: _____

Social Security #: _____ DOB: _____

INSURED'S INFORMATION

- Yes ____ No ____ is patient covered by insurance for orthodontic treatment? Group # _____
  - If Yes, insurance company name _____
- Insured Name _____ Insured Soc. Sec. # _____ Insured DOB: _____
- In case of Emergency contact: _____ Phone: _____
- Family Dentist: _____ Phone: _____ Physician: _____
- Which best describes how you first heard about our office? (Check one)

  ____ dentist ____ dental school ____ friend ____ another orthodontist ____ internet

  ____ mailer ____ other, please describe _____
  - If you were referred by a friend, whom should we thank? _____

MEDICAL HISTORY

Has the patient ever had: (Please circle "Y" for yes or "N" for no)

Y N A.I.D.S.	Y N Auto Immune	Y N Epilepsy	Y N Heart Disease
Y N A.I.D.S. Related Complex	Y N Bleeding	Y N Endocrine Problems	Y N Hepatitis
Y N Anemia	Y N Blood Disease	Y N Emotional Problems	Y N Herpes
Y N Artificial Prosthesis	Y N Bone Disorders	Y N Head or Face Injury	Y N HIV
Y N Asthma	Y N Diabetes	Y N Hearing Disorder	Y N Nervous Disorders
			Y N Rheumatic Fever

Other (describe): _____

Comments: _____

Yes ___ No ___ Has the patient been under the care of a physician during the past two years, other than for routine examination?

Condition: _____

Drugs or medication currently being used: _____

Birth Defects: _____

Yes ____ No ____ Has the patient reached puberty (menstruation, hair)?

RESPIRATORY HISTORY

Does the patient:

1. Have allergies to: Seasonal grasses: Yes _____ No _____ Food: Yes _____ No _____
   Drugs: Yes _____ No _____ (If yes, list drugs): Other: _____
   _____ _____
   _____ _____
2. Yes _____ No _____ Snore when sleeping?
3. Yes _____ No _____ Breath through mouth?
4. Yes _____ No _____ Have frequent colds?
5. Yes _____ No _____ Have frequent "stuffy nose?"
6. Yes _____ No _____ Have frequent sore throat or tonsillitis?
7. Yes _____ No _____ Have chewing or swallowing difficulty?
8. Yes _____ No _____ Has the patient received medical treatment from allergist or ear, nose and throat specialist?
   If yes: Dates: _____ By Whom: _____
9. Has the patient had: Nasal Surgery: Yes ___ No ___ Tonsils removed: Yes ___ No ___ Adenoids removed: Yes ___ No ___

DENTAL HISTORY

Yes ____ No ____ Does the patient have pain or clicking in jaw joint?

Yes ____ No ____ Have any teeth been injured due to accidents or blows to the mouth?

Yes ____ No ____ Has the patient received or been requested to receive speech correction?

Yes ____ No ____ The following habits are of interest, List information as it pertains to this patient:

Yes ____ No ____ Thumb sucking until age _____ Yes ____ No ____ Teeth Grinding

Yes ____ No ____ Finger sucking until age _____ Yes ____ No ____ Tongue thrusting

Yes ____ No ____ Lip-biting or sucking Yes ____ No ____ Other habits

Yes ____ No ____ Has the patient had any unusual dental experiences?

Specify: _____

Date of last dental checkup _____ Were the patient's teeth cleaned? Yes ____ No ____

ORTHODONTIC HISTORY

• Yes ____ No ____ Has the patient had previous orthodontic consultation? Yes ____ No ____ Previous treatment?

• Date: _____ Dr.: _____

• Why did patient seek this consultation? _____

• What is the primary problem? _____

• What is expected from orthodontic treatment? _____

• Additional comments you wish to make: _____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of individual completing this form: _____

Relationship to patient: _____ **Today's Date:** _____

Reviewed by Dr.: _____ **Date:** _____