Welcome

to the office of

DR. TIMOTHY J. STUHLMILLER SPECIALIST IN ORTHODONTICS

We welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime!

ADULT HEALTH HISTORY FORM

PATIENT INFORMATION

Today's Date:_____

Name:_____

Last, First MI

Height:_____ Weight: _____ ❑Male ❑Female

D.O.B.:_____ Age:_____

Address:_____

City, State, Zip:_____

Home Phone: _____

Employer: _____

Occupation:_____

Where and when are the best times to reach you?:_____

_____

REFERRED BY:_____

GENERAL DENTIST

Dentist Name:_____

Date of last visit:_____

MARITAL STATUS

❑Single ❑Married ❑Separated ❑Widowed ❑Divorced

SPOUSE'S INFORMATION

Name:_____

Home Phone: _____

Work Phone:_____

Employer:_____

Occupation: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____

Relationship:_____

Billing Address:_____

City, State, Zip:_____

Insurance:_____

Social Security Number:_____

Home Phone: _____

Work Phone:_____

ARE YOU AWARE AND DO YOU AGREE THAT SOME APPOINTMENTS MAY INFRINGE ON WORK TIME?

❑Yes ❑No

What are the main concerns you would like orthodontics to accomplish? _____

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? ❑Yes ❑No

Have there been any injuries to face, mouth, teeth, or chin?

❑Yes ❑No If yes, please describe: _____

_____

_____

_____

_____

Have adenoids or tonsils been removed? ❑Yes ❑No

Have you ever been informed of any missing or extra permanent teeth? ❑Yes ❑No

TMJ/TMD CONCERNS

Have you had any pain and/or tenderness in your jaw joint?

❑Yes ❑No If yes, please describe:_____

_____

ORAL HYGIENE

Do you brush your teeth daily? ❑Yes ❑No

Do you floss your teeth daily? ❑Yes ❑No

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ❑Yes ❑No If yes, please describe:_____

_____

_____

_____

Physician:_____

Phone: _____

Date of last visit:_____

What is your physical health? ❑Good ❑Fair ❑Poor

Please list all drugs which you are currently taking:_____

_____

_____

Please list all drug allergies:_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

❑Yes ❑No Abnormal Bleeding
❑Yes ❑No Allergic to any Drugs
❑Yes ❑No Allergic to Latex or Metals
❑Yes ❑No Allergic to Plastics
❑Yes ❑No Any Hospital Stays
❑Yes ❑No Any Operations
❑Yes ❑No Asthma
❑Yes ❑No Cancer
❑Yes ❑No Congenital Heart Defect
❑Yes ❑No Convulsions / Epilepsy
❑Yes ❑No Diabetes
❑Yes ❑No Handicap / Disabilities
❑Yes ❑No Hearing Impaired
❑Yes ❑No Heart Murmur
❑Yes ❑No Hemophilia
❑Yes ❑No HIV+ / AIDS
❑Yes ❑No Kidney / Liver Problems
❑Yes ❑No Rheumatic / Scarlet Fever
❑Yes ❑No Tuberculosis

Please describe any medical problems you have had:_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING HABITS?

❑Yes ❑No Clenching / Grinding Teeth
❑Yes ❑No Lip Sucking / Biting
❑Yes ❑No Nail Biting
❑Yes ❑No Mouth Breather
❑Yes ❑No Nursing Bottle Habits
❑Yes ❑No Speech Problems
❑Yes ❑No Thumb / Finger Sucking
❑Yes ❑No Tongue Thrust

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the orthodontic staff to perform the necessary orthodontic services I may need.

_____

Signature of Patient *Date*