Welcome

to the office of

DR. TIMOTHY J. STUHLMILLER SPECIALIST IN ORTHODONTICS

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

ABOUT YOUR CHILD

Today's Date:_____

Name:_____

Last, First MI

Height:_____ Weight: _____ ❑Male ❑Female

Child's D.O.B.:_____ Age:_____

Address:_____

City, State, Zip:_____

Home Phone: _____

School: _____ Grade:_____

Siblings: _____

_____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name:_____

Relationship:_____

Do you have legal custody of this child? ❑Yes ❑No

REFERRED BY:_____

GENERAL DENTIST

Dentist Name:_____

Date of last visit:_____

PARENTS MARITAL STATUS

❑Single ❑Married ❑Separated ❑Widowed ❑Divorced

MOTHER'S INFORMATION

❑Mother ❑Step Mother ❑Guardian

Name:_____

Height: _____

Home Phone: _____

Work Phone:_____

Employer:_____

Occupation: _____

Where and when are best times to reach you? _____

_____

FATHER'S INFORMATION

❑Father ❑Step Father ❑Guardian

Name:_____

Height: _____

Home Phone: _____

Work Phone:_____

Employer:_____

Occupation: _____

Where and when are best times to reach you?_____

_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____

Relationship:_____

Billing Address:_____

City, State, Zip:_____

Insurance:_____

Social Security Number:_____

Home Phone: _____

Work Phone:_____

Employer:_____

PERSON RESPONSIBLE FOR MAKING APPOINTMENTS

Name:_____

Home Phone: _____

Work Phone:_____

ARE YOU AWARE AND DO YOU AGREE THAT SOME APPOINTMENTS WILL INFRINGE ON SCHOOL TIME?

❑Yes ❑No

Please continue on back of form

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ❑Yes ❑No

Have there been any injuries to face, mouth, teeth, or chin? ❑Yes ❑No

List any musical instruments played:_____

_____

Have adenoids or tonsils been removed? ❑Yes ❑No

Has your child ever been informed of any missing or extra permanent teeth? ❑Yes ❑No

TMJ/TMD CONCERNS

Has your child had any pain and/or tenderness in your jaw joint? ❑Yes ❑No If yes, please describe:_____

_____

ORAL HYGIENE

Does your child brush your teeth daily? ❑Yes ❑No
Does your child floss your teeth daily? ❑Yes ❑No

IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? ❑Yes ❑No If yes, please describe: _____

_____

_____

_____

Physician:_____

Phone: _____

Date of last visit:_____

Child's physical health? ❑Good ❑Fair ❑Poor

Has puberty begun? ❑Yes ❑No

Please list all drugs your child is currently taking: _____

_____

_____

Please list all your child's drug allergies: _____

_____

HAS YOUR CHILD 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 your child has had:

_____

_____

_____

DOES YOU CHILD 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 child's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that my child may need.

_____

Signature of Parent/Guardian *Date*