HILLER ORTHODONTICS

Building Smiles. Treating People.

PATIENT INFORMATION FORM

Patient Name _____ Preferred Name _____ Sex: ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip_____

Home Phone _____ Alternate Phone / Cell _____

Birthdate _____/_____/_____ Email Address _____

Patient's Interests or Hobbies _____

_____

Who noticed an orthodontic problem? ☐ Friend ☐ Patient ☐ Dentist ☐ Parent ☐ Hygienist ☐ Physician ☐ Other

Whom may we thank for referring you to our office? (A dentist? Our advertising?) _____

Do you know a patient in our practice? ☐ Yes ☐ No If so, whom? _____

RESPONSIBLE PARTY INFORMATION

If the patient is a minor, please fill out the information of the legal guardian.

Name_____ Relationship to Patient _____

Mailing Address _____ City _____ State _____ Zip_____

How long? _____ years _____ months Home Phone _____ Alt Phone/Cell _____

Email Address _____ Contact Preference _____

Previous Address (if less than 3 years) _____ City _____ State ____ Zip_____

Employer _____ Occupation _____ / _____ years _____ months

Work Phone _____ SS# _____ Birthdate _____/_____/_____

Orthodontic Insurance? ☐ Yes ☐ No Marital Status ☐ M ☐ S ☐ D ☐ W ☐ ReM

Dennis C. Hiller, DDS, MSD

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Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential. Please sign below.

Physician's Name: _____ Dentist's Name: _____

Has the patient experienced any health problems?	☐ No	☐ Yes	Comments/Complications: _____
Any major change in the patient's health recently?	☐ No	☐ Yes	Comments/Complications: _____
Is the patient currently under a physician's care?	☐ No	☐ Yes	Comments/Complications: _____
Is the patient currently taking medications?	☐ No	☐ Yes	Comments/Complications: _____
Is the patient using tobacco products of any kind?	☐ No	☐ Yes	Comments/Complications: _____
Is the patient allergic to dust/pollen/medication?	☐ No	☐ Yes	Comments/Complications: _____
Has the patient had their tonsils/adenoids removed?	☐ No	☐ Yes	Comments/Complications: _____

Please check if the patient has ever had of the following conditions:

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Bone Disorder
- ☐ Bronchitis
- ☐ Cancer/Tumor
- ☐ Chemo/Bisphosphonate
- ☐ Cong. Heart Defect
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Endocrine Disorders
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequent Headaches
- ☐ Growth Disorders
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Herpes (Fever Blisters)
- ☐ Hives/Rash
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Liver Disease/Hepatitis
- ☐ Mouth Breather
- ☐ Nervous/Anxious
- ☐ Nickel Sensitivity
- ☐ Radiation
- ☐ Rheumatic Fever
- ☐ Tonsillitis
- ☐ Tuberculosis

Are there any other conditions or problems that you think we should know about?

_____

_____

_____

_____

_____

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Is there unfinished care to be completed for the patient with your dentist? ☐ Yes ☐ No

Explain:_____

Is the patient apprehensive about dental treatment? ☐ Yes ☐ No

Has the patient had an unpleasant experience in a dental office? ☐ Yes ☐ No

Has the patient had any facial or dental injuries? ☐ Yes ☐ No

Does the patient have a history of thumb or finger sucking? ☐ Yes ☐ No

Does the patient play any musical instruments? ☐ Yes ☐ No

Has the patient consulted with an orthodontist previously? ☐ Yes ☐ No

Have teeth (either primary or permanent) been removed by a dentist? ☐ Yes ☐ No

Has the patient had any previous orthodontic treatment? ☐ Yes ☐ No

Are you satisfied with prior treatment? ☐ Yes ☐ No

Has the patient had a periodontal (gum) treatment? ☐ Yes ☐ No

Please check if there is a history of:

- ☐ Clenching Teeth
- ☐ Muscular soreness around head & neck
- ☐ Jaw Joint Soreness
- ☐ Grinding Teeth
- ☐ Headaches (more than normal)
- ☐ Jaw Joint Clicking
- ☐ Speech Problems (If so, which sounds?)

  _____
- ☐ Jaw Joint Popping
- ☐ Ringing in the Ears
- ☐ Mouth Breathing: Awake or Asleep?

Is there any other information that may be helpful?

_____

_____

_____

_____

_____

Patient/Responsible Party Signature Date

GROWTH INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has the patient reached puberty? ☐ Yes ☐ No

Girls: Has she started menstruation? ☐ Yes ☐ No If so, when? _____

Boys: Has his voice changed? ☐ Yes ☐ No If so, when? _____

Height _____ Weight _____ Do you feel growth is completed? ☐ Yes ☐ No

Father's Height _____ Mother's Height _____

Frequency of dental check-ups for the patient: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never

Date of Last Visit: _____

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