William B. Miller, DMD
Specialist in Orthodontics

Patient Information

E-mail: _____ Date: _____

Patient's full legal name: _____ Preferred name: _____

Patient's date of birth: _____ Patient's age: _____ Height: _____ Weight: _____

Patient's home address: _____

Name of responsible party: _____

Address of responsible party: _____

Phone numbers of responsible party: Home: _____ Work: _____ Cell: _____

Relationship of responsible party to patient: _____

Place of employment: _____ Occupation: _____

Briefly describe in your own words what you feel is wrong with the patient's teeth. _____

What are the results you hope to achieve from orthodontic treatment? _____

What are your main concerns about starting orthodontic treatment? _____

Do you feel that the patient needs orthodontic treatment (braces)?	YES	NO
Does the patient have a positive attitude toward treatment?	YES	NO
Do you feel that the patient will cooperate with treatment?	YES	NO
Has the patient had any previous orthodontic treatment?	YES	NO

If yes, when and by whom? _____

What was the nature of treatment? _____

Has the patient had any previous orthodontic consultations?	YES	NO

If yes, when and by whom? _____

Are you aware that some appointments will require missing school/work?	YES	NO
Are you aware that a FINANCIAL AGREEMENT must be made and signed by the financially responsible party before treatment can begin?	YES	NO
Has our office ever treated another member of your family?	YES	NO

If yes, name of other family member: _____

(Please leave the space below for the doctor's notes and proceed to the next page.)

Reviewed by: Date:

Growth and Development

(This information is needed for growing children/adolescents *under 16 years of age*; if the patient is an adult or an adolescent 16 years old or older, please leave this page blank and proceed to the next page.)

Is the patient adopted? YES NO If yes, at what age was the patient adopted? _____

(If the patient is adopted, it is understood that all the answers to the following questions may not be known; therefore, answer them to the best of your knowledge.)

How many other children are in the family? _____ How many are older than the patient? _____

Who does the patient most resemble? (circle one) MOTHER FATHER BOTH EQUALLY NEITHER

Mother's height: _____ Father's height: _____

How does the patient's present height compare to other children his/her own age and sex? (circle one)

TALLER THAN OTHERS ABOUT THE SAME HEIGHT NOT AS TALL AS OTHERS

Has the patient started showing signs of puberty? YES NO If yes, at what age? _____

At what age did the patient's first "baby" tooth appear? _____ First permanent tooth? _____

At what age did the patient start……. walking? _____ talking? _____ school? _____

School presently attended: _____ Grade/year in school: _____

How is the patient's school performance? (circle one) ABOVE AVERAGE AVERAGE BELOW AVERAGE

How would you describe the patient's personality? (please circle all that apply)

sensitive	nervous	self-conscious	calm
shy	introverted	extroverted	cooperative
friendly	withdrawn	quiet	hyperactive

How would you describe the patient's level of maturity compared to other children his/her age? (circle one)

MUCH MORE MATURE ABOUT AS MATURE

A LITTLE MORE MATURE NOT AS MATURE

(Please leave the space below for the doctor's notes and proceed to the next page.)

Reviewed by: Date:

Dental History

Name of patient's dentist: _____ For how long? _____

Dentist's address: _____ City: _____ State: _____

Date of patient's last dental examination: _____ Date of last dental cleaning: _____

How often does the patient have dental examinations? _____ Dental cleanings? _____

How often does the patient brush? _____ How often does the patient floss? _____

What other dental cleaning aids (such as a *WaterPik* or *sonicare*) does the patient use? _____

Does the patient have any dental problems now? (toothaches, sensitive teeth, cavities, etc.) YES NO

If yes, please describe the problems. _____

_____

Does patient's bite feel uncomfortable?	Y	N	Are any teeth sensitive to hot or cold?	Y	N
Does patient clench or grind teeth?	Y	N	Are any teeth sensitive to sweets?	Y	N
If yes, while awake or asleep? _____			Are any teeth sensitive to biting or chewing?	Y	N
Does patient have any oral habits such as			Are there any mouth odors or bad tastes?	Y	N
thumb/finger sucking, nail biting, etc.?	Y	N	Any problem with frequent fever blisters, ulcers,		
If yes, describe: _____			cold sores, etc.?	Y	N
Does patient frequently bite lip or cheek?	Y	N	Do gums bleed or hurt?	Y	N
Does patient primarily breathe through mouth?	Y	N	Are gums swollen or inflamed?	Y	N
Does patient smoke or use tobacco products?	Y	N	Are there areas where gums have receded?	Y	N
If yes, describe: _____			Are there any loose teeth?	Y	N
Does patient eat a well-balanced diet?	Y	N	Have any teeth drifted or moved?	Y	N
Does patient eat a high sugar diet?	Y	N	Has there been any change in the bite?	Y	N
Has patient ever experienced:			Does food sometimes get caught between teeth?	Y	N
clicking or popping of jaw?	Y	N	If yes, where? _____		
pain in jaw joint, ear, or jaw?	Y	N			
difficult opening or closing of jaw	Y	N	Has patient ever had:		
jaw locking open or closed?	Y	N	orthodontic treatment (braces)?	Y	N
tired or sore muscles in jaw, neck, or			oral surgery?	Y	N
shoulders, especially in the morning?	Y	N	periodontal treatment (gum surgery)?	Y	N
Does patient chew primarily on one side?	Y	N	endodontic treatment (root canal)?	Y	N
Does patient avoid chewing on either side?	Y	N	bite adjustment (equilibration)?	Y	N
Is patient nervous about dental visits?	Y	N	occlusal appliance (bite splint/guard)?	Y	N
Has patient ever had an upsetting or troubling			a serious injury to the mouth, teeth or jaws?	Y	N
dental experience?	Y	N	If yes, describe when and how:		
If yes, describe when and how: _____			_____		
_____			_____		

Is there any additional information that we might need prior to starting orthodontic treatment in our office? Y N

If yes, please describe: _____

_____

_____

(Please leave the space below for the doctor's notes and proceed to the last page.)

Reviewed by: Date:

Medical History

Name of person completing this form (if not the patient): _____

Name of patient's physician: _____

Physician's address: _____ City: _____ State: _____ Zip: _____

Physician's phone number: _____ Date of last physical exam: _____

Please answer the following questions by circling "Yes" or "No" and providing information for all "Yes" responses

Is the patient presently under the care of a physician?	Yes	No	If yes, for what condition? _____
Is the patient taking any drugs, medicines, or pills?	Yes	No	If yes, what? _____
Has the patient ever had a reaction to any medications?	Yes	No	If yes, what was the reaction? _____
Is the patient allergic to anything?	Yes	No	If yes, what? _____
Has the patient ever been hospitalized?	Yes	No	If yes, for what condition? _____
Has the patient ever had major surgery?	Yes	No	If yes, for what condition? _____
Has the patient ever had a blood transfusion?	Yes	No	If yes, for what reason? _____
Has the patient ever had any broken bones?	Yes	No	If yes, what bones? _____
If yes, were there any healing problems?	Yes	No	If yes, what problems? _____
Has the patient ever had any injury/trauma to the face, jaws, jaw joint (TMJ), or teeth?	Yes	No	If yes, what happened? _____
Has the patient had tonsils/adenoids removed?	Yes	No	If yes, at what age? _____
Does the patient have frequent breathing problems/ sinus congestion/colds/sore throats/ear infections?	Yes	No	

Does the patient have any chronic problems involving:

The heart?	Yes	No
The lungs?	Yes	No
The liver?	Yes	No
The kidneys?	Yes	No
The blood?	Yes	No
The bones or joints?	Yes	No

Has the patient ever been diagnosed as having:

AIDS?	Yes	No
HIV?	Yes	No
Hepatitis A	Yes	No
Hepatitis B	Yes	No
Tuberculosis?	Yes	No
Venereal disease?	Yes	No

Please circle any of the following diseases, conditions, or treatments that the patient has now or has had in the past

thyroid problems	measles	heart problems	cerebral palsy
whooping cough	chicken pox	arthritis/rheumatism	bone disorders
pneumonia	mumps	rheumatic fever	prolonged bleeding
tonsillitis	scarlet fever	epilepsy	emotional problems
polio	endocrine problems	high fever	anemia
asthma	diphtheria	mouth ulcers	nutritional problems
AIDS	hepatitis	diabetes	STD's
hay fever	HIV positive	cold sores/fever blisters	allergies
sinus troubles	hemophilia	radiation therapy	chemotherapy
cancer/tumors	jaundice	emphysema	swollen ankles
shortness of breath	restricted diet	ulcers	artificial joints
glaucoma	contact lenses	chronic cough	congenital heart problems
chest pain	high blood pressure	stroke	pacemaker
cortisone medications	nervousness/anxiety	neurological disorders	migraines/headaches
vertigo	tinnitus (ringing in ears)		

Please describe any other medical problems not listed above: _____

_____

Signature: _____ Relationship to patient: _____