MCMILLEN ORTHODONTICS LTD **PATIENT HISTORY FORM - ADULT**

**** Important: Please Complete History Form and Bring to First Appointment ****

Name _____Date _____

Social Security # _____ Birth date _____ Age _____

Address _____ City _____State _____ Zip _____ Phone _____

Employed By _____Business Address _____ Phone _____

Special hobbies or interests _____

Other people you know in treatment _____

Who can we thank for referring you to our office? _____

Dentist _____ Phone _____ Address _____

Physician _____ Phone _____ Address _____

Dental Insurance ☐ Yes ☐ No Orthodontic Insurance ☐ Yes ☐ No

Spouse's Name _____ Occupation _____

Employed By _____ Phone _____ Business Address _____

Social Security #_____

Person Financially Responsible _____Social Security # _____Relationship _____

Phone _____Address _____ Zip _____

MEDICAL HISTORY. (Circle yes or no and fill in blanks where required)

1. Are you in good health?	Yes	No
2. Date of last dental exam _____ Is work completed?	Yes	No
3. Have tonsils and/or adenoids been removed? At what age? _____	Yes	No
4. Are height and weight normal for age?	Yes	No
5. Frequent colds, sore throat, or ear infections?	No	Yes
6. Any major illness, AIDS, etc.?	No	Yes
If yes, list _____		
7. Any allergies or drug sensitivity?	No	Yes
If yes, list _____		
8. Taking medication now?	.No	Yes
If yes, list _____		
9. Under medical care now?	No	Yes
If yes, reason _____		
10. Are you adopted?	No	Yes

11. Circle any of the following for which you have been treated:

Diabetes	Asthma	Prolonged bleeding	Tonsillitis
Arthritis	Epilepsy	Nervous disorders	Brain injury
Heart trouble	Rheumatic fever	Endocrine problems	Tuberculosis

DENTAL HISTORY: (circle answer)

1. Have there been any injuries to the face, mouth, or teeth? . . . . . No Yes
2. Have you ever sucked your thumb or fingers? Until what age? _____ . . . . . No Yes
3. Have you ever had habits, such as lip biting or tongue thrusting or finger nail biting? . . . . . No Yes
4. Do you have any speech problems?. . . . . No Yes
5. Have you ever had any speech therapy? . . . . . No Yes
6. Are you a mouth breather while asleep or awake? . . . . . No Yes
7. Are you aware of any missing or extra permanent teeth? . . . . . No Yes
8. Have you ever had orthodontic treatment? . . . . . No Yes
9. Name of orthodontist _____
10. What are you or your dentist most concerned about? _____

_____

11. Signature _____ Date _____

DENTAL INSURANCE INFORMATION:

Employee Name _____Employee Social Security # _____

Membership # _____Employee Group # _____

Group Name _____

Name of Employer _____ Phone _____

Address _____

Name of Insurance Carrier _____ Phone # _____

Address _____

BENEFITS OF ORTHODONTICS

AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand the above paragraph. I also understand that my diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in the above medical or dental history.

_____ _____

Patient Date

CREDIT REFERENCES MAY BE CHECKED