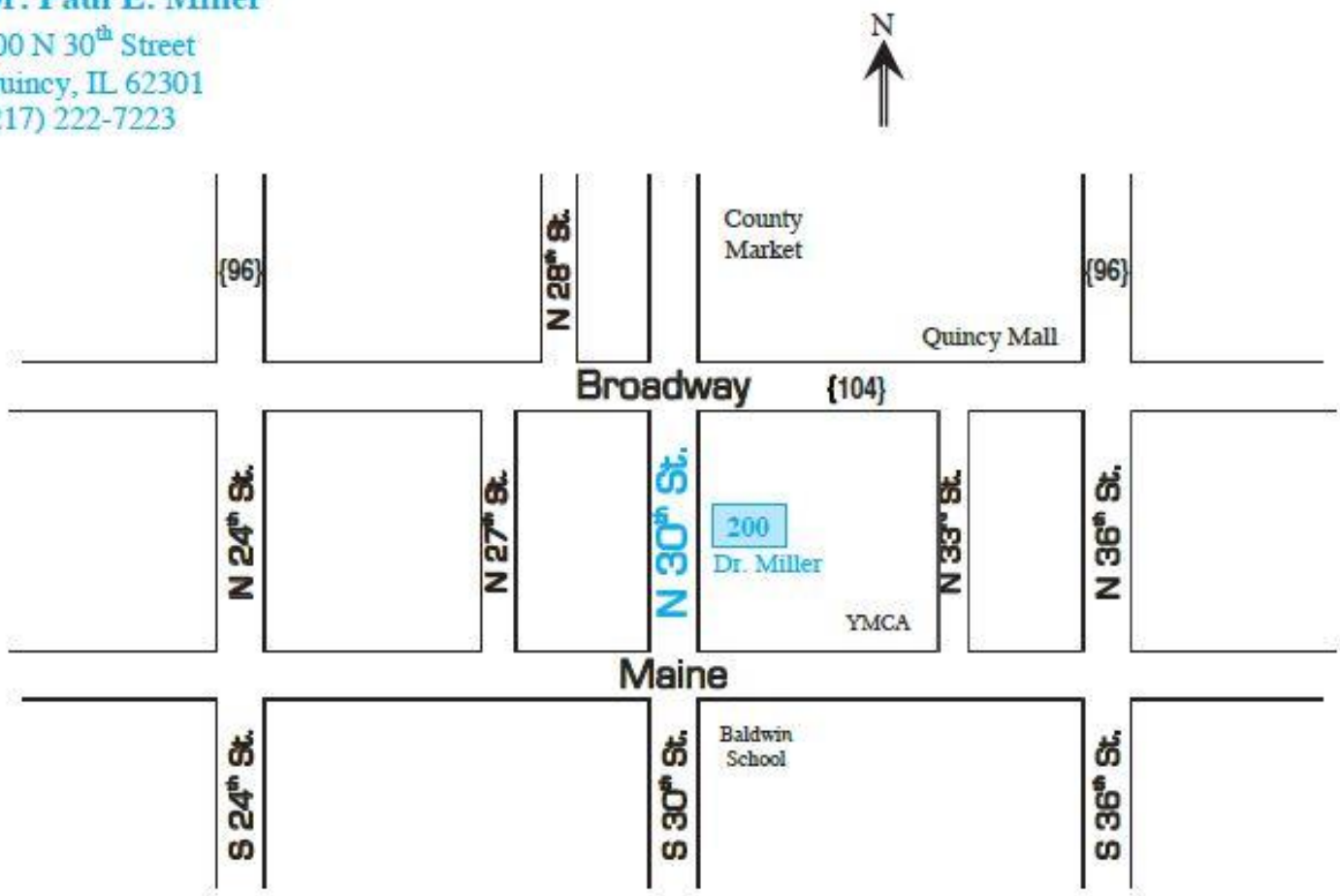
Dr. Paul E. Miller
200 N 30th Street
Quincy, IL 62301
(217) 222-7223



Thank you for selecting our practice for your orthodontic treatment.

Paul E. Miller, DDS, PC
Specialist in Orthodontics and Dento-Facial Orthopedics
B RACE
200 N. 30th Street • Quincy, IL 62301 • (217) 222-7223

DATE:

PATIENT INFORMATION

(Please answer **all** Questions)

Patient's Name: Last Name: _____, 1st_____MI_____Sex: ☐M ☐F DOB: _____
Patient's Address: _____

Home Phone: _____ Cell Phone:_____

ADULT Patient: Years at above Address: _____ Previous address if less than 3 years:_____

School/Employer: _____ Grade/Dept. _____ Soc. Sec. No.: _____

ADULT Patient: Years with Above Employer: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

If patient is a minor, give parents or guardians name _____
Whom may we thank for referring you to our office? _____
Family seen in our office: _____

Email - Parent: _____ **Patient** _____

RESPONSIBLE PARTY INFORMATION

Father/Husband _____ Home Phone: _____Cell Phone: _____

Address: _____ How long at this address? _____ years

☐ ***Same Address as Patient***

Previous address if less than 3 years at above address: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced Date of Birth: _____

Employer: _____ How long working for this employer: _____ years

Work Phone: _____ Occupation: _____ Soc. Sec. No: _____

Mother/Wife: _____ Home Phone: _____Cell Phone: _____

Address:_____ How long at this address?_____ years

☐ ***Same Address as Patient***

Previous address if less than 3 years at above address: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced Date of Birth: _____

Employer: _____ How long working for this employer: _____ years

Work Phone: _____ Occupation: _____ Soc. Sec. No: _____

DENTAL INSURANCE INFORMATION

(Please bring a copy of the Insurance Card(s) to put on file)

Primary INS. Co.: _____ Group/Plan #: _____ ID #: _____

INS. Co. Address _____ INS. Co. Phone # _____

Name of Insured: _____ DOB:_____ SSN: _____ Employer: _____

Insured's Address (If not listed as RP above):_____ Phone# _____

Secondary INS. Co.: _____ Group/Plan #: _____ ID #: _____

INS. Co. Address _____INS. Co. Phone # _____

Name of Insured: _____ DOB:_____ SSN: _____ Employer:_____

Insured's Address (If not listed as RP above):_____ Phone# _____

EMERGENCY INFORMATION

In case we can't reach you, whom can we contact?

Name: _____ Phone: _____ Relationship to Patient: _____

I understand that where appropriate, a credit grade may be obtained.
Signature (Parent's signature if minor) _____ **Date:** _____

American Association of Orthodontists

Medical History

(Please answer all Questions)

Name of Family Physician: _____ Date of last visit to physician: _____

Are there any medical specialists you see regularly? Specialty: _____

Date of last time *complete physical exam:* _____ Examining doctor: _____

Pre-Medicate? □No
Rx: _____

- Has this patient been advised by a physician that they require an *antibiotic prior to dental treatment?* □No If □Yes, Antibiotic: _____ How is antibiotic given? _____
- This patient's general health at this time is:…….. □Good, □Fair, □Poor Comment? _____
- Is this patient presently under the care of a physician? …. □No, If □Yes, For what? _____
- Is this patient presently taking medications?…… □No, If □Yes, which medications: □bisphosphonates _____
- Has this patient had tonsils or adenoids removed?..... □No, If □Yes, □Tonsils (on date_____) □Adenoids (on date_____)
- Does this patient have a *Chronic Illness?*..... □No, If □Yes, Comment? _____
- Has this patient ever had a serious illness? ..... □No, If □Yes, Comment? _____
- Has this patient ever been *Hospitalized?* ..... □No, If □Yes, For what? _____
- Is this patient allergic to antibiotics (penicillin, etc)?..... □No, If □Yes, which medications: _____
- Does this patient have anesthetic reactions?..... □No, If □Yes, □Local □General: _____
- Is this patient allergic to anything else?..... □No, If □Yes, what? □Sulfa Drugs □Aspirin □Ibuprofen □Environmental □Metals □Plastics □Latex Comments: _____

Allergy Alert? □No
_____

- **Does this patient now have, or ever had any of the following problems?**

□No □Yes Rheumatic Fever	□No □Yes Hepatitis (type?_____)	□No □Yes Diabetes
□No □Yes Endocarditis	□No □Yes Aids or HIV Positive	□No □Yes Epilepsy
□No □Yes Heart Condition	□No □Yes Tuberculosis	□No □Yes Stroke
□No □Yes Heart Pacemaker	□No □Yes Lived with tuberculin person	□No □Yes Stomach Ulcers
□No □Yes Heart Angina	□No □Yes Respiratory Lung Disease	□No □Yes Tonsillitis
□No □Yes Heart Attack (coronary)	□No □Yes Asthma	□No □Yes Headaches
□No □Yes Mitral Valve Prolapse	□No □Yes Venereal Disease	□No □Yes Earaches
□No □Yes Congenital Heart Disease	□No □Yes Herpes (Oral Cold Sores)	□No □Yes Jaw Pain
□No □Yes Artificial Heart Valve	□No □Yes Inflammatory Rheumatism	□No □Yes Jaw Clicking (noises)
□No □Yes Heart Surgery (date:_____)	□No □Yes Arthritis	□No □Yes Emotional Problems (note below)
□No □Yes Heart Murmur	□No □Yes X-Ray (radiation) cancer therapy	□No □Yes Tobacco Use
□No □Yes High Blood Pressure	□No □Yes Glaucoma	
□No □Yes Low Blood Pressure	□No □Yes Fainting Spells	
□No □Yes Blood Disorders/Bleeding Problems	□No □Yes Kidney Trouble	
□No □Yes Anemia	□No □Yes Liver Disease	

Medical Alert? □No _____
_____

Please comment on ☒Yes responses: _____

- Does this patient have any other medical problems not listed? □No, If □Yes, Comment: _____

Patient's Growth History:

What is this patient's height?_____Ft. _____In.
Child's present age: _____years, _____months
Is child adopted? □No □Yes
Any recent signs of increased growth? □No □Yes

If a *BOY*, has his voice changed? □No □Yes
If a *GIRL*, has she started menstruation? □No □Yes
MOTHER'S present height: _____Ft. _____In.
FATHER'S present height: _____Ft. _____In.

Additional Growth?
□ No □ Yes
□ Possibly

Comments: _____

Patient's Family History of:

	If ☒**YES**, which family member	Comments on Family Histories:
□No □Yes Diabetes	_____	_____
□No □Yes Cancer or Skin Cancer	_____	_____
□No □Yes Infectious Disease	_____	□TB □Hepatitis □HIV+ □Aids _____
□No □Yes Heart Disease	_____	_____
□No □Yes High Blood Pressure	_____	_____
□No □Yes Organ Disease	_____	□Liver □Kidney □Lung _____
□No □Yes Emotional Problems	_____	□Anxiety □Depression _____
□No □Yes Stroke	_____	_____
□No □Yes Arthritis	_____	_____

Other family history comments: _____

Medical History Reviewed: Dr.'s Initials: _____

Dental History

Name of Family Dentist: _____ Date of last dental visit: _____

How many times a day do you ***BRUSH?*** □0 □1 □2 □3+ How many times a day do you ***FLOSS?*** □0 □1 □2+

- Has this patient been examined by another orthodontist? □No, If □Yes, Date: _____, Name of orthodontist _____
- Has this patient ever had *orthodontic treatment* (braces)? □No, If □Yes, Date: _____, Name of orthodontist _____
- Has this patient been treated for TMJ problems? □No, If □Yes, Date: _____, Name of dentist _____
- Has this patient been treated for *gum* disease? □No, If □Yes, What kind of treatment? _____
- Has this patient had *root canal* treatment? □No, If □Yes, Which Teeth? _____
- Has this patient had *other* dental specialist treatment? □No, If □Yes, What? _____
- Does this patient have any of the oral habits? □No, If □Yes, □Thumb sucking □Finger sucking □Lip Biting
  Comments? _____ □Tongue Thrusting □Speech problems □Mouth Breathing

Habit Alert? □No _____

- Does this patient have any *TMJ* (jaw joint) *Symptoms* □No, If □Yes, □Grinding □Clenching □Jaw Joint Noises □Headaches/Neckaches
  □Jaw Joint Pain □Facial or Ear Pain □Locking or difficulty moving of Jaws □Dental/Facial Trauma □Arthritis
  Comments? _____

TMJ Alert? □No _____

- Does this patient have any *Missing Permanent Teeth?* □No, If □Yes, Comment: _____
- Does this patient have any *Extra Permanent Teeth?* □No, If □Yes, Comment: _____
- Does this patient typically have *bleeding gums?* □No, If □Yes, Comment: _____
- Does this patient have *sores, lumps or irritated tissue* in the mouth? □No, If □Yes, Comment: _____
- Has this patient had any *injuries* to his/her teeth? □No, If □Yes, @Age: _____ □Chipped □Broken □Lost _____
- Has this patient had any *injuries* to his/her face or jaws or mouth? □No, If □Yes, @Age: _____ Comment: _____
- Does this patient have or been informed of any *Speech Problems?* □No, If □Yes, Comment: _____
- Are there any other comments about this patient's dental history? □No, If □Yes, Comment: _____

Patient and Family Concerns

- Is this patient anxious about having orthodontic treatment? □No, If □Yes, Comment: _____
- What are this patient's concerns about orthodontic treatment? □ Appearance of Teeth □ Oral Function □ Crowding/Spacing □ Protrusion
  □ Other concerns or comments: _____
- Does the family dentist have any concerns about this treatment? □ No, If □Yes, Comment: _____
- Do other family members have any concerns about this treatment? □ No, If □Yes, Comment: _____

Family History of orthodontic treatment:

- *Mother:* □No, If Yes: Dentist _____ Were you satisfied with the results? □Yes, □No _____
- *Father:* □No, If Yes: Dentist _____ Were you satisfied with the results? □Yes, □No _____
- *Sister:* □No, If □Yes: Dentist _____ Were you satisfied with the results? □Yes, □No _____
- *Brother:* □No, If □Yes: Dentist _____ Were you satisfied with the results? □Yes, □No _____

Comments: _____

☺ If your dentist has taken new **full mouth** or **panoramic x-rays** in the past six months, *please bring them with you to the exam.*

☺ If you have had **orthodontic records** taken in the past six months, *please bring them with you to the exam.*

☺ If you are currently wearing an **orthodontic appliance or TMJ Splint**, *please bring it with you to the exam.*

☺ Is there any other medical or dental condition that we should know about? □ No, If □Yes, Comment _____

I the undersigned have completed this medical and dental health history and certify that the preceding information is true and correct. This practice cannot be held responsible for any problems arising out of inadequate information not disclosed here. If there are any future changes in this information, I will inform this practice of these changes. I also understand that a credit grade may be obtained when appropriate.

Signature of *person filling out this history*: _____ Date completed/signed: _____
Signature of *TC* who reviewed this history: _____ Date reviewed/signed: _____
Dr. Miller's signature after reviewing entire history: _____ Date reviewed/signed: _____