Welcome!

ID No. _____
Model No. _____

Adult Health History

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date _____

Patient's Name _____
Last First Middle

Soc. Sec. No. _____ Birthdate _____

Address _____
Street

_____
City State Zip

How long at this address? _____

Previous Address (if less than 3 yrs.) _____
Street

_____
City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Employer _____ No. Years Employed _____

Occupation _____

Whom may we thank for referring you to our office? _____

_____

Other family members seen by our office _____

_____

Marital Status _____

Spouse's Name _____

Work Phone _____

Soc. Sec. No. _____ Birthdate _____

Employer _____ No. Years Employed _____

Occupation _____

I understand that where appropriate, credit bureau reports may be obtained.

_____ _____
Signature (Parent's signature if minor) Date

Dental Insurance Information

Insured's Name _____
Last First Middle

Relationship to Patient _____

Identification No./Soc. Sec. No. _____

Insurance Co. _____

Group No. _____ Phone _____

Insurance Co. Address _____
Street

_____
City State Zip

Do you have dual coverage? Y N

If yes, Insured's Name _____

Relationship to Patient _____

Identification No./Soc. Sec. No. _____

Insurance Co. _____

Group No. _____ Phone _____

Insurance Co. Address _____
Street

_____
City State Zip

Your Dentist

Previous/Present Dentist _____

_____

Last Visit Date _____

Emergency Information

Name of nearest relative not living with you

_____
Last First Middle

Address _____
Street

_____
City State Zip

Home Phone _____ Work Phone _____

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WHEELER ORTHODONTICS

Dental History

What is the reason for this visit? _____

_____

Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Do you now/have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N
How would you describe your current dental health? Good Fair Poor
Do you like your smile? Y N Do your gums bleed? Y N
How many times a week do you floss? _____ How many times a week do you brush? _____
Have you inherited any facial/dental characteristics? Y N
If yes, explain _____

_____

Medical History

Physician's Name _____ Last Visit Date _____
How would you describe your current physical health? Good Fair Poor
Explain _____
Have your tonsils/adenoids been removed? Y N
Are you taking any prescription/over-the-counter drugs? Y N
Please list each one _____

For Women Are you taking birth control pills? Y N
Are you pregnant? Y N Week No. _____
Are you nursing? Y N

Have you ever had any of the following diseases/medical conditions?

Y N Heart Attack/Stroke	Y N Psychiatric Problems	Y N Cancer/Chemotherapy
Y N Epilepsy/Seizures/Fainting	Y N Heart Murmur	Y N Diabetes
Y N Rheumatic Fever	Y N Drug/Alcohol Abuse	Y N HIV+/AIDS
Y N Venereal Disease	Y N Heart Surgery/Pacemaker	Y N Hemophilia/Abnormal Bleeding
Y N Shingles	Y N Ulcers/Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Kidney Problems	Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints	Y N Asthma	Y N Artificial Valves
Y N Difficulty Breathing	Y N Sinus Problems	Y N Hospitalization
Y N High/Low Blood Pressure	Y N Hepatitis	Y N Fever Blisters
Y N Blood Transfusion	Y N Severe/Frequent Headaches	Y N Emphysema/Glaucoma
Y N Arthritis	Y N Tuberculosis (TB)	

Please list any serious medical condition not listed above that you have ever had

_____

Do you need to be premedicated with antibiotics? Y N
Are you allergic to any of the following?

Y N Penicillin	Y N Erythromycin	Y N Dental Anesthetics	Y N Codeine
Y N Aspirin	Y N Tetracycline	Y N Latex	Y N Nickel/Metals

Please list any other drugs/materials that you are allergic to _____

_____

Do you have any of the following habits?
Y N Thumb/Finger Sucking Y N Lip Sucking/Biting Y N Nail Biting Y N Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

American Association of Orthodontists

www.wheelerortho.com

Dr. Wheeler's Notes

Problem _____

_____

Class Right
Molar I EO II III **Canine** I EO II III
Class Left
Molar I EO II III **Canine** I EO II III

Overbite Open Slight Moderate Deep _____ %
Overjet Negative Slight Moderate Severe _____ mm

Upper Arch
Spacing Mild Moderate Severe Central Diastema
Crowding Mild Moderate Severe
Arch Form Broad Ovoid Constricted Omega V

Lower Arch
Spacing Mild Moderate Severe
Crowding Mild Moderate Severe
Arch Form Broad Ovoid Constricted Omega V

Crossbite
Unilateral R L Bilateral Individual Tooth No. _____

Midlines

Curve of Spee Flat Mild Moderate Deep Reverse
Curve of Wilson Flat Accentuated

TMJ **Noises** R L **Pain** R L **Hx of Locking** Open Closed

Habits Thumb Sucking Tongue Thrusting
Lip Biting Nail Biting

Pano Evaluation
Missing Teeth **Impacted Teeth**

Anomalies _____ **Short Roots**

Treatment

Bond 6-6	Hyrax/RPE
Bond Upper 6-6/Lower 7-7	Bluegrass
Bond 7-7	TMJ Splint
Band 6's/Bond 5-5	RPHG
Band 6's and 7's/Bond 5-5	BDA LLA
Band 6's/Bond 2-2	Nance ULA

Other _____

Brackets Stainless Ceramic
Ceramic Upper/Metal Lower Gold

Referrals
Extractions/Restorative Needs

R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
R 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 L
R 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 L
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Permanent

R E D C B A | A B C D E L
R A B C D E | F G H I J L
R T S R Q P | O N M L K L
R E D C B A | A B C D E L

Primary

Perio/Surgical Hygiene _____ Frenectomy _____
Gingival Grafting _____ Expose/Bond No. _____

DDI
Treatment _____ months **Recall** _____ months
Fee _____

_____