WELCOME!

DAVID L. WILKINSON D.D.S., M.S.
Orthodontics for Children and Adults

ADULT HEALTH HISTORY

ABOUT YOU

Name: _____

I prefer to be called: _____

☐ Male ☐ Female

Birthdate: _____ Social security #: _____

Email address: _____

Home address: _____

How long have you lived at this address: _____

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Home #: _____ Pager/cell #: _____

Work #: _____

Employer: _____

Employer's address: _____

Length of employment: _____ Occupation: _____

When/where are the best times to reach you? _____

Whom may we thank for referring you? _____

_____

Other family members seen by Dr. Wilkinson? _____

_____

General Dentist: _____ Last visit: _____

INSURANCE INFORMATION

Orthodontic coverage? ☐ Yes ☐ No

Insurance Co. name? _____

Insurance Co. phone #? _____

Insurance Co. address? _____

Policy holder's name: _____

Policy holder's birth date: _____

Policy holder's relationship to patient: _____

Policy holder's group #: _____

Policy holder's policy #: _____

Policy holder's employer: _____

Policy holder's address: _____

Policy holder's social security #: _____

TODAY'S DATE: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's name: _____ Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Do you smoke or use tobacco of any form? ☐ Yes ☐ No

For Women: Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Have you ever had/experienced any of the following?

- ☐ Abnormal bleeding
- ☐ Aids/HIV+
- ☐ Anemia/radiation treatment
- ☐ Artificial bones/ joints/valves
- ☐ Asthma/arthritis
- ☐ Blood transfusion
- ☐ Cancer/chemotherapy
- ☐ Congenital heart defect
- ☐ Diabetes/tuberculosis
- ☐ Difficulty breathing
- ☐ Drug/alcohol abuse
- ☐ Emphysema/glaucoma
- ☐ Epilepsy/seizures/fainting
- ☐ Fever blisters/herpes
- ☐ Heart attack/stroke
- ☐ Heart murmur
- ☐ Heart surgery/pacemaker
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/low blood pressure
- ☐ Hospitalization
- ☐ Kidney problems
- ☐ Micral valve prolapse
- ☐ Psychiatric problems
- ☐ Rheumatic fever
- ☐ Severe/frequent headaches
- ☐ Shingles
- ☐ Sinus problems
- ☐ Ulcers/colitis
- ☐ Venereal disease

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals/plastics
- ☐ Penicillin
- ☐ Tetracycline

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

_____

Dr. David L. Wilkinson, D.D.S., M.S.
Orthodontics for children and adults
Bryden Canyon Professional Center
3326 4th Street Ste 6-A Lewiston, ID 83501
www.wilkinsonortho.com
Phone: (208) 746-0479 Fax: (208) 798-3000

DENTAL HISTORY

Do you like your smile? ☐ Yes ☐ No

What are the main concerns that you would like orthodontics to address?

_____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

By whom? _____ When? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you require antibiotics before dental work? ☐ Yes ☐ No

How many times daily do you brush? _____

Do you floss your teeth daily? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Is your water fluoridated? ☐ Yes ☐ No

Are you taking fluoride supplements? ☐ Yes ☐ No

Do you have or have you ever had any of the following habits?

☐ Lip sucking/biting ☐ Nail biting

☐ Speech problems ☐ Tongue thrust

☐ Mouth breather ☐ Clench/grind teeth

☐ Thumb/finger sucking

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes: ☐ While awake ☐ While asleep

Have your adenoids or tonsils been removed? ☐ Yes ☐ No

Do you have any speech problems? _____

Do you have any missing or extra permanent teeth? ☐ Unsure ☐ Yes ☐ No

Do you still have any wisdom teeth? ☐ Unsure ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you play any musical instruments? ☐ Yes ☐ No

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relationship: _____

Home #: _____ Work #: _____

ADDITIONAL INFORMATION

Any additional information you can give us would be appreciated as the more we know about each other, the better we can help manage your treatment both at home and in the office.

_____

_____

_____

_____

_____

OFFICE USE

I have verbally reviewed the medical/dental information above with the patient named herein.

Staff initials: _____

Dr. Wilkinson's comments: _____

_____

_____

_____

_____

_____

Thank you for filling out this form completely.

I affirm that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature of patient: _____ Date: _____

Dr. David L. Wilkinson, D.D.S., M.S.
Orthodontics for children and adults
Bryden Canyon Professional Center
3326 4th Street Ste 6-A Lewiston, ID 83501
www.wilkinsonortho.com
Phone: (208) 746-0479 Fax: (208) 798-3000