



Richard J. Wolterman, D.M.D.

OFFICE USE ONLY

Exam Date _____
Office: BM _____ MILF _____
Computer # _____

ADULT PATIENT HISTORY

GENERAL INFORMATION:

Name _____ Birthdate _____ Age _____ Male _____ Female _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ SS # _____
Marital Status Single _____ Married _____ Widowed _____ Divorced _____ email _____
Employer _____ Address _____ Occupation _____
Responsible Party to Pay _____
Address (if not the same) _____ Phone _____
Persons to contact in case of emergency:
Name _____ Relation to you _____ Phone _____
Name _____ Relation to you _____ Phone _____

SPOUSE INFORMATION:

Name _____ Spouse SS # _____
Employer _____ Address _____ Phone _____
Occupation _____

MEDICAL HISTORY:

Physician _____ Address _____
Patient's General Health: Good _____ Fair _____ Poor _____
Are you presently under a physician's care? _____
Are you taking any medication? _____ If so, what? _____
Are you allergic to or had an unusual reaction to any medication? _____
Have you had any major operations? _____
Have you ever had a serious accident involving head injuries? _____
Have you ever had an accident involving whiplash? _____
Any history of mental illness? _____
Height _____ Weight _____
Have tonsils or adenoids been removed? _____ If so, at what age? _____
Frequent colds, sore throats, or ear infections? _____
Have you been diagnosed or treated for any of the following: Aids _____ Asthma _____ Heart _____ Arthritis _____ Anemia _____
Diabetes _____ Epilepsy _____ Emotional _____ Endocrine _____ Rheumatic Fever _____ Speech Problems _____ Scoliosis _____
Learning Disabilities _____ Hyperactivity _____ High Blood Pressure _____ Blood Disease _____ Speech Therapy _____
Stomach or Intestinal Disease _____ Yellow Jaundice or Hepatitis _____ Tumors or Growths _____ Other _____
If you have answered yes to any of the above questions, please explain. _____

Are you allergic to any known materials resulting in hives, asthma, eczema, etc. ? _____
Have any wounds healed slowly or presented other complications? _____
Are you pregnant? _____
Do you have a headache more than once per week? _____
Are you bothered by chronic neck, shoulder, or jaw pain? _____
Do you ever hear clicking or popping in your jaw joint area? _____

(OVER)

DENTAL HISTORY:

Dentist _____ Location _____

Last exam? _____

Have there been any injuries to the mouth or teeth? _____

Are you a mouth breather while asleep or awake? _____

Are you aware of any missing or extra permanent teeth? _____

Have your wisdom teeth been extracted? _____

Do you have difficulty chewing or swallowing? _____

Do your gums bleed while brushing or flossing? _____

How many times per month do you floss? _____

Are you aware of any tooth grinding or clenching? _____ Day or night? _____

Have you ever had instructions on the correct method of brushing your teeth? _____

Have you ever had instructions on the care of your gums? _____

Do you chew on only one side of your mouth? _____ If so why? _____

Do you at the present time have any dental complaints? _____

Do you experience any soreness or sensitivity in your mouth? (cold, hot, sweet foods, etc.) If yes, locate: _____

Have you ever been diagnosed as having periodontal disease? _____

When was your last full mouth X-RAY taken? _____ Where? _____

What are you or your dentist most concerned about? _____

What concerns you most about the thought of braces? Appearance _____ Cost _____ Pain _____ Length of time _____ Will it work _____

Other _____

Has anyone in the family had orthodontic treatment? _____

If yes, was Dr. Wolterman their orthodontist? Yes _____ No _____

If yes, please write the patient's name here _____

Were you aware of any ortho problems prior to the referral? Yes _____ No _____ If so what: _____

Please name everyone we can thank for you being here: _____

FINANCIAL ARRANGEMENTS DETERMINED BY CREDIT APPROVAL

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY - THANK YOU

Stage: _____ Appointments: _____

Will Call: Patient's (why a w/c) _____

Appointment Comments (w/c for T-15, T-20) _____

Select Code: _____

Condition Codes: CLL _____ CLIII _____ CLI & CLII _____ CLIII _____ CLI DIVII _____