



Patient Information

Patient Name _____
Last, First, MI
Nickname _____
Male _____ Female _____
Birth date ____/____/____ Age _____
Home Address _____
City _____ State _____ Zip _____
School _____ Grade _____
Hobbies/Sports _____

Mother's Information

Responsible for Account YES NO
Name _____
Guardian YES NO
SS# _____ Birth date ____/____/____
Employer _____
Work Phone _____
Home Phone _____
Cell Phone _____
Email _____
Marital Status: Married Divorced Single Separated

Father's Information

Responsible for Account YES NO
Name _____
Guardian YES NO
SS# _____ Birth date ____/____/____
Employer _____
Work Phone _____
Home Phone _____
Cell Phone _____
Email _____
Marital Status: Married Divorced Single Separated

Who is accompanying the patient today?
Name _____
Relationship to patient _____

Primary Dental Insurance

Policy Owners Name _____
Relationship to Patient _____
Birth date ____/____/____
SS# _____
Employer _____
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone _____
Policy Number _____

Secondary Dental Insurance

Policy Owners Name _____
Relationship to Patient _____
Birth date ____/____/____
SS# _____
Employer _____
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone _____
Policy Number _____

Dental History

General Dentist _____

Date of Last Exam _____

Has the patient ever had or been evaluated for orthodontic treatment? YES NO

Have there been any injuries to the face, mouth, teeth or chin? YES NO

Has the patient ever been informed of any missing or extra permanent teeth? YES NO

Does the patient brush his/her teeth daily? YES NO

Has puberty begun? YES NO

Has menstruation begun? (Girls) YES NO

Has the patient ever experienced pain or discomfort in the jaw joint (TMJ/TMD)? YES NO

Has the patient ever had any of the following habits?

- | | |
|-------------------------------|---------------------------------|
| Y N Clenching/Grinding | Y N Lip Sucking/Biting |
| Y N Nail Biting | Y N Tongue Thrusting |
| Y N Mouth Breathing | Y N Thumb/Finger Sucking |
| Y N Soda Pop Drinker | Y N Snoring |

Health History

Physician _____

Phone _____

Is the patient currently under the care of a physician?
YES NO

Please list all medications patient is currently taking:

Please list all medications/things patient is allergic to:

Has the patient ever had any of the following medical conditions?

- | | |
|--------------------------------------|------------------------------------|
| Y N Abnormal Bleeding | Y N Allergies to any drugs |
| Y N Allergies to Latex/Metals | Y N Allergies to plastic |
| Y N Asthma | Y N Cancer |
| Y N Congenital Heart Defects | Y N Convulsions/ Epilepsy |
| Y N Diabetes | Y N Handicaps/ Disabilities |
| Y N Hearing Impairment | Y N Heart Murmur |
| Y N Hemophilia | Y N Hepatitis |
| Y N HIV+/AIDS | Y N Hospitalization |
| Y N Kidney/Liver Problems | Y N Operations |
| Y N Rheumatic/ Scarlet Fever | Y N Tuberculosis |

Please discuss any serious medical problems that the patient has / had: _____

I understand that the information I have provided is correct to the best of my knowledge. Dr. Schilling reserves the right to charge for broken appointments, excessive breakage of appliances or extended treatment time due to non-compliance. I accept and understand that regardless of custodial situation, I am ultimately responsible for all expenses incurred in this office. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of parent or guardian

Date