



Patient Information

Name _____

 Last, First, MI Mr Mrs Ms Dr

I prefer to be called _____

Male _____ Female _____

Birth date ____/____/____ Age _____

Marital Status: Married Divorced Single Separated

SS# _____

Home Address _____

City _____ State ____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Occupation _____

Employer _____

Work Phone _____

Work Address _____

City _____ State ____ Zip _____

Where/when is the best time to reach you? _____

Spouse's Information

Name _____

SS# _____ Birth date ____/____/____

Employer _____

Employer Address _____

Work Phone _____

Emergency Contact

Name _____

Relationship to you _____

Address _____

City _____ State ____ Zip _____

Phone _____

Who referred you to our office?

Name: _____

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 _____

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

Have you ever had or been evaluated for orthodontic treatment? YES NO

Have you ever had an injury to your face, mouth, teeth or chin? YES NO

Do you have any missing or extra permanent teeth? YES NO

Do you brush your teeth daily? YES NO

Do you floss daily? YES NO

Your current dental health is: GOOD FAIR POOR

Do you like your smile? YES NO

Do your gums ever bleed? YES NO

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

Do you have 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 |

Are you allergic to any of the following?

- | | | |
|----------------|---------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Anesthetic | Y N Metals/Plastics | Y N Other |

Please list any other medication/things that you are allergic to:

Health History

Your current medical condition is: GOOD FAIR POOR

Are you currently under the care of a physician?

YES NO Please Explain _____

Physician _____

Phone _____

Are you taking any prescription/over-the-counter drugs?

YES NO

Please list each one _____

Have you ever had any of the following conditions?

- | | |
|------------------------------------|------------------------------|
| Y N Abnormal Bleeding | Y N Anemia/Radiation |
| Y N Artificial Bones/joints/valves | Y N Arthritis |
| Y N Asthma | Y N Blood Transfusion |
| Y N Cancer/Chemotherapy | Y N Congenital Heart Defects |
| Y N Diabetes | Y N Difficulty Breathing |
| Y N Drug or Alcohol Abuse | Y N Epilepsy/ Seizures |
| Y N Emphysema | Y N Fever Blisters/Herpes |
| Y N Glaucoma | Y N Heart Attack |
| Y N Hearing Impairment | Y N Heart Murmur |
| Y N Heart Surgery/ Pacemaker | Y N Hemophilia |
| Y N Hepatitis | Y N High/Low Blood Pressure |
| Y N HIV+/AIDS | Y N Hospitalization |
| Y N Kidney/Liver Problems | Y N Mitral Valve Prolapse |
| Y N Operations | Y N Pregnancy |
| Y N Psychiatric Problems | Y N Rheumatic/Scarlet Fever |
| Y N Severe Headaches | Y N Shingles |
| Y N Sinus Problems | Y N Tuberculosis |
| Y N Ulcers/Colitis | Y N Venereal Disease |

Please discuss any serious medical problems that you have/had _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

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 my situation, I am ultimately responsible for all expenses incurred in this office. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date