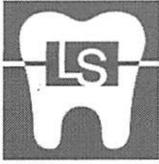

LINDSEY D. SCHILLING DMD MSD, Inc.

Specialist in Orthodontics

19 W. Monroe Street, Norwalk, OH 44857 • 419-668-1700
450 Northwest Street, Bellevue, OH 44811 • 419-483-7137
3274 Northeast Catawba Road, Port Clinton, OH 43452
www.TheOrthodonticSpecialist.com

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 ______________________________

Please Continue to Reverse Side

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