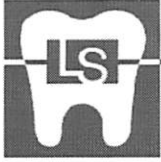

LINDSEY D. SCHILLING DMD MSD, Inc.

Specialist in Orthodontics

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450 Northwest Street, Bellevue, OH 44811 • 419-483-7137
3274 Northeast Catawba Road, Port Clinton, OH 43452
www.TheOrthodonticSpecialist.com

Patient Information

Patient Name ______________________________
Last, First, MI

Nickname ______________________________

Male ______ Female ______

Birth date ____ /____ /____ Age ______

Home Address ______________________________

City ____________________ State ______ Zip __________

School ______________________________ Grade _____

Hobbies/Sports ______________________________

Siblings Names and Birthdates ____________________

____

Mother's Information

Guardian YES/NO Responsible for Account YES/NO

Name ______________________________

Home Address ______________________________

City ____________________ State ______ Zip __________

SS# ____________________ Birth date ____ /____ /____

Home Phone ______________________________

Cell Phone ______________ Work Phone ____________

Email ______________________________

Employer ______________________________

Marital Status: Married Divorced Single Separated

Father's Information

Guardian YES/NO Responsible for Account YES/NO

Name ______________________________

Home Address ______________________________

City ____________________ State ______ Zip __________

SS# ____________________ Birth date ____ /____ /____

Home Phone ______________________________

Cell Phone ______________ Work Phone ____________

Email ______________________________

Employer ______________________________

Marital Status: Married Divorced Single Separated

Who is accompanying the patient today?

Name ______________________________

Relationship to patient ______________________________

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 ____________________

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: ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

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

____________________ ____________________
Signature of parent or guardian 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 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