Schmidtorthodontics

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(715) 365-1777

Rhinelander • Minocqua • Eagle River

Date________________

Confidential Responsible Party Information

A B C

Name______________________________ Marital Status__________
Last First Middle

Residence______________________________
Street City State Zip

Mailing Address______________________________
Street City State Zip

How long at this address__________ Home Phone__________ Work Phone__________

Previous Address (if less than three yrs.)______________________________
Street City State Zip

Email Address______________________________

Social Security #__________ Birthdate__________ Relationship to Patient__________

Employer__________ Occupation__________ No. Years Employed__________

Spouse's Name______________________________ Relationship to Patient__________
Last First Middle

Employer__________ Occupation__________ No. Years Employed__________

Social Security #__________ Birthdate__________ Work Phone__________

Dental Insurance Information

Policy Holder's Name______________________________ Subscriber #__________

Insurance Company__________ Group #__________ Union Local #__________

Insurance Co. Address__________ Insurance Co. Phone__________

Policy Holder's Employer______________________________

Do you have dual coverage? No ☐ Yes ☐ **If yes:**

Policy Holder's Name______________________________ Subscriber #__________

Insurance Company__________ Group #__________ Union Local #__________

Insurance Co. Address__________ Insurance Co. Phone__________

Policy Holder's Employer______________________________

Emergency Information

Name of nearest relative not living with you______________________________

Complete Address______________________________

Phone__________ Relationship__________

I understand credit bureau report may be obtained, and/or insurance signature will be kept on file where appropriate.

Signature (Parent's signature if minor)______________________________

Updates (date & initial) ______________________________

OVER➤

Confidential Patient Information

Patient's Name ________________________________ Last ______ First ______ Middle

Address ________________________________ Street ______ City ______ State ______ Zip

Home Phone ______________ Birthdate ______________ School ______________

Email ________________________________

How did you hear about our office? ☐ Patient ______ ☐ Radio ☐ Newspaper ☐ Internet ☐ Dentist ☐ INS PPO ______

MEDICAL HISTORY

HAVE YOU EVER HAD	YES	NO
Facial Injuries	☐	☐
Endocrine or Thyroid problems	☐	☐
Kidney problems	☐	☐
Immune Deficient	☐	☐
Cardiovascular concerns	☐	☐
Bone Disorders	☐	☐
Asthma	☐	☐
Hives	☐	☐
Excessive Bleeding	☐	☐
Black & Blue Tendency	☐	☐
Diabetes	☐	☐
Mononucleosis	☐	☐
Tuberculosis	☐	☐
Rheumatic Fever	☐	☐
Low/High Blood Pressure	☐	☐
Cancer, tumor, radiation treatment or chemotherapy	☐	☐
Epilepsy	☐	☐
Arthritis	☐	☐
Glaucoma	☐	☐
Hepatitis	☐	☐
AIDS or HIV Infection	☐	☐
Tonsils or Adnoids Removed	☐	☐
Heart/Mitral Mumur	☐	☐
Premedication Needed	☐	☐
Do you use tobacco products	☐	☐

HAVE YOU EVER HAD	YES	NO
Hyperactive Condition	☐	☐
Frequent Headaches/Colds/Sore Throat	☐	☐
Eye, ear, nose or throat condition	☐	☐
Skin Disorder	☐	☐
Have you ever taken weight reducing medications	☐	☐
Eating Disorder	☐	☐
Female: Menses	☐	☐
Male: Voice Change	☐	☐
Depression	☐	☐
Learning Disabilities	☐	☐
Has the patient ever taken Bisphosphonates?	☐	☐
Are you under a physician's care?	☐	☐

Reason: ________________________________

Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication ______________ Taken for ______________

Medication ______________ Taken for ______________

Medication ______________ Taken for ______________

	YES	NO
Have you any other health problems/illnesses we should know about?	☐	☐
Does patient wear contact lenses?	☐	☐
Women: Are you pregnant at the present time?	☐	☐

DENTAL HISTORY

Family Dentist ________________________________ Date of last cleaning appointment ________________________________

What are the reasons for consulting with our office today? ________________________________

NOW OR IN THE PAST, HAS THE PATIENT HAD:	YES	NO
Any missing or extra teeth?	☐	☐
Trauma to primary (baby) or permanent teeth?	☐	☐
Teeth sensitive to hot or cold; teeth throb or ache?	☐	☐
Jaw fractures, cysts, or mouth infections?	☐	☐
Root canals, crowns, or bridges?	☐	☐
All dental work is complete	☐	☐
Bleeding gums, bad taste or mouth odor	☐	☐
Periodontal "gum problems" and or treatment	☐	☐
Any teeth irritating cheek, lip, tongue or palate?	☐	☐
Frequent canker sores or cold sores?	☐	☐
Thumb, finger, or sucking habit? Until what age? ______	☐	☐
Concerned about spaced, crooked or protruding teeth?	☐	☐
Abnormal swallowing habit (tongue thrusting)?	☐	☐
History of speech problems?	☐	☐
Mouth breathing habit, snoring or difficulty in breathing?	☐	☐
Tooth grinding or jaw clenching?	☐	☐
Any pain in jaw or ringing in the ears?	☐	☐
Any pain or soreness in the muscles of the face or around the ears?	☐	☐
Difficulty chewing or jaw opening?	☐	☐
Aware or concerned about under or over developed jaw?	☐	☐
Any relative with similar tooth or jaw relationships?	☐	☐
Taking any forms of fluoride?	☐	☐
Brushes at least two times a day	☐	☐
Flosses at least once a day	☐	☐
Ever had a prior orthodontic examination or treatment?	☐	☐

Allergies or reactions to any of the following:	YES	NO
Local anesthetics (Novocaine or Lidocaine)	☐	☐
Aspirin, Ibuprofen, Tylenol	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐
Metals (jewelry, clothing snaps) specify ______	☐	☐
Latex (gloves, balloons)	☐	☐
Sodium lauryl sulfate	☐	☐
Vinyl	☐	☐
Acrylic	☐	☐
Animals	☐	☐
Foods (specify) ______	☐	☐
Other ______	☐	☐

Notes: ________________________________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed (Parent or Guardian) ________________________________ Date Signed ______________