DYLAN SCHNEIDER, DDS, MS, LLC
ORTHODONTICS

PATIENT FORMS – CHILD

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Thank you for selecting our orthodontic health care team! We will strive to provide you with the best possible orthodontic care. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION – Please Print (Confidential)

Name: ______ (First) ______ (Middle) ______ (Last) ______ (Nickname) Gender: Male __ Female

Age: ______ Date of Birth: ___/___/___ Primary Phone: ( ) ______ Secondary Phone: ( ) ______

Home Address: ______ City: ______ Zip: ______

Patient's School: ______ Grade: ______ Hobbies: ______

Person to Contact in Case of Emergency: ______ Relationship: ______ Phone: ( ) ______

Name of Dentist: ______

How long has he/she been a patient at above? ______ Date of Last Dental Check-up: ______

Referred By: __ Friend: ______ Dentist __ Online Website Other: ______

Does the patient play a musical instrument? ______ Engage in contact sports? ______

Has patient had any previous orthodontic treatment or orthodontic consultations? __Yes __No If yes, when? ______

If so, where? ______ What were you told? ______

What is/are main concern(s) about the patient's teeth? ______

FAMILY INFORMATION

Guardian Name: ______ Relationship: ______

Address: ______ City: ______ State: ___ Zip: ______

Employer: ______ Occupation: ______ Work Phone: ( ) ______

Mobile/Cell Phone: ( ) ______ Email Address: ______

Guardian Name: ______ Address: ______ City: ______ State: ___ Zip: ______

Employer: ______ Occupation: ______ Work Phone: ( ) ______

Mobile/Cell Phone: ( ) ______ Email Address: ______

Have any family members been previously treated at our offices? __ Yes No Names/Offices: ______

RESPONSIBLE PARTY

Name of Person Financially Responsible for this Account: ______ Relationship to Patient: ______

Address: ______ City: ______ State: ___ Zip: ______ Phone: ( ) ______

Date of Birth: ___/___/___ SSN: ___-___-___

Employer: ______ Address: ______ Phone: ( ) ______

INSURANCE INFORMATION

Does Patient Have Orthodontic Insurance Coverage? __ Yes No Not Sure

If yes, Name of Subscriber: ______ Date of Birth: ___/___/___ SSN of Subscriber: ______-______

Insurance Company Carrying Policy: ______ Group#: ______ Member ID #: ______

Name of Subscriber (Secondary): ______ Date of Birth: ___/___/___ SSN of Subscriber: ______-______

Insurance Company Carrying Policy: ______ Group#: ______ Member ID #: ______

Please bring your insurance information to the office at your first visit.

PATIENT FORMS – CHILD

PATIENT MEDICAL HISTORY

Physician: ____________________ Office Phone: (____) ____________ Date of Last Exam: ____/____/____

	Yes	No
1. Is patient under medical treatment now?		
2. Has patient ever been hospitalized for any surgical operation or serious illness within the last 5 years?		

If yes, please explain: ______________________________

____

	Yes	No
3. Is patient taking any medication(s) including non-prescription medicine?		

If yes, please list: ______________________________

____

	Yes	No
4. Has patient ever taken Phen-Fen/Redux?		
5. Does patient use tobacco?		
6. Does patient use controlled substances?		
7. Is patient wearing contact lenses?		

8. Is patient allergic to or have they had any reaction to the following:

	Yes	No
Local anesthetic (e.g. Novocaine)		
Penicillin or any Antibiotics		
Sulfa Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any Metals (e.g. nickel, mercury, etc.)		
Latex Rubber		
Other (please list): ______________________		

9. Women only:

	Yes	No
a) Is patient pregnant or think she may be pregnant?		
b) Is patient taking oral contraceptives?		

Does patient have or have they had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Heart Disease			Chest Pains		
Heart Attack			Cardiac Pacemaker			Easily Winded		
Rheumatic Fever			Heart Murmur			Stroke		
Swollen Ankles			Angina			Hay Fever/Allergies		
Fainting/Seizures			Frequently Tired			Tuberculosis		
Asthma			Anemia			Radiation Therapy		
Low Blood Pressure			Emphysema			Glaucoma		
Epilepsy/Convulsions			Cancer			Recent Weight Loss		
Leukemia			Arthritis			Liver Disease		
Diabetes			Joint Replacement or Implant			Heart Trouble		
Kidney Diseases			Hepatitis/Jaundice			Respiratory Problems		
Aids or HIV Infections			Sexually Transmitted Disease			Mitral Valve Prolapse		
Thyroid Problem			Stomach Troubles/Ulcers			Other: ______________________		

PATIENT DENTAL HISTORY

	Yes	No
1. Do patient's gums bleed while brushing or flossing?		
2. Are teeth sensitive to hot or cold liquids/foods?		
3. Are teeth sensitive to sweet or sour liquids/foods?		
4. Does patient feel pain to any teeth?		
5. Has patient had any sores or lumps in or near mouth?		
6. Has patient had any head, neck or jaw injuries?		
7. Has patient ever experienced any of the following problems with their jaw:		
a) Clicking		
b) Pain [joint, ear, side of face]		
c) Difficulty in opening or closing		
d) Difficulty in chewing		

	Yes	No
8. Does patient have frequent headaches?		
9. Does patient clench or grind teeth?		
10. Does patient bite lips or cheeks frequently?		
11. Has patient ever had difficult extractions?		
12. Has patient ever had any prolonged bleeding?		
13. Has patient ever had any orthodontic treatment?		
14. Does patient require antibiotics for dental treatment?		
15. Has patient ever received oral hygiene instructions regarding care of teeth/gums?		

16. What are chief orthodontic (dental) concerns(s)?

____

____

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to patient's health. I authorize Dylan Schneider, DDS, MS, LLC to release any information including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dylan Schneider, DDS, MS, LLC any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

X

____

Signature of Patient/Responsible Party Relationship to Patient

Doctor's Comments: ______________________________

____

Signature: Date: