DATE .....

schwab orthodontics

☐ I ACKNOWLEDGE THAT I RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

INITIALS.....

PATIENT

NAME last..... first..... middle..... ○ MALE ○ FEMALE

DATE OF BIRTH ..... SOCIAL SECURITY # ..... EMAIL ADDRESS .....

ADDRESS ..... city..... state..... zip.....

PHONE home.....work.....cell.....cell provider.....

WHOM CAN WE THANK FOR REFERRING YOU?.....

HOW DID YOU HEAR ABOUT OUR OFFICE? ○ friend ○ phone book ○ billboard ○ newspaper ○ dentist's office ○ internet

GENERAL DENTIST ..... LAST DENTAL VISIT .....

MAIN CONCERN / REASON FOR VISIT .....

SCHOOL (if patient is child) ..... GRADE LEVEL .....

FAMILY

FATHER'S (or husband's) NAME .....CELL PHONE .....CELL PROVIDER.....

ADDRESS (if different from patient) ..... HOME PHONE (if different from patient) .....

EMPLOYER ..... HOW LONG? ..... WORK PHONE .....

POSITION ..... EMAIL ADDRESS.....

MOTHER'S (or wife's) NAME .....CELL PHONE..... CELL PROVIDER.....

ADDRESS (if different from patient) ..... HOME PHONE (if different from patient) .....

EMPLOYER ..... HOW LONG? ..... WORK PHONE .....

POSITION ..... EMAIL ADDRESS.....

RESPONSIBLE PARTY

NAME last..... first..... middle..... YEARS AT CURRENT RESIDENCE .....

RESIDENCE ..... city..... state..... zip.....

MAILING ADDRESS ..... city..... state..... zip.....

PHONE home.....work.....cell.....cell provider.....

FORMER ADDRESS (if less than 3 years in current) ..... city..... state..... zip.....

SOCIAL SECURITY # ..... DATE OF BIRTH ..... RELATIONSHIP TO PATIENT .....

EMPLOYER ..... POSITION ..... NUMBER OF YEARS .....

ORTHODONTIC INSURANCE

INSURED'S NAME ..... INSURED'S SOCIAL SECURITY # .....

INSURANCE COMPANY ..... GROUP # .....

INSURED'S DATE OF BIRTH ..... INSURED'S PHONE .....

EMERGENCY

NEAREST RELATIVE NOT LIVING WITH YOU ..... RELATIONSHIP TO PATIENT ..... PHONE .....

COMPLETE ADDRESS ..... city..... state..... zip.....

I realize it may be appropriate to utilize a credit report in determining a payment plan.

SIGNATURE (parent signature if patient is a minor) ..... DATE .....

UPDATES (date and initials) ....

NAME ..... **DATE** .....

MEDICAL HISTORY

PHYSICIAN ..... AGE AT ONSET OF PUBERTY..... FEMALES: Pregnant? Y N

MEDICATIONS.....

ALLERGIES or DRUG SENSITIVITIES? Y N If yes, explain .....

IN GOOD HEALTH? Y N If no, explain.....

ANY MAJOR ILLNESSES? Y N If yes, explain.....

Anemia	Y N	Heart Disease/Murmur	Y N	Frequent Colds/Sinusitis	Y N	Tonsils Removed: Age	
Blood Disease	Y N	Tuberculosis	Y N	Tonsillitis	Y N	Adenoids Removed: Age	
Diabetes	Y N	Prolonged Bleeding	Y N	Mouthbreathing	Y N	Asthma	Y N
Hepatitis	Y N	Endocrine Problems	Y N	Cancer / Radiation	Y N	Artificial Joints, Valve	Y N
Bone Disorders	Y N	Herpes	Y N	HIV or AIDS	Y N	Arthritis	Y N
Jaundice	Y N	Epilepsy	Y N	Osteoporosis Meds	Y N	Rheumatic Fever	Y N
Behavior Issues	Y N	ADD / ADHD	Y N	Other			

DENTAL HISTORY

SEVERE HEAD/FACE INJURIES? Y N If yes, explain .....

PREVIOUS ORTHODONTIC CONSULTATION? Y N

PREVIOUS TREATMENT FOR HEADACHES? Y N

STRIKE SOME TEETH BEFORE OTHERS? Y N

PREVIOUS ORTHODONTIC TREATMENT? Y N

LOOSE TEETH / FOOD TRAPS? Y N

SERIOUS/DIFFICULT DENTAL TREATMENT? Y N

PREVIOUS TREATMENT FOR JAW PAIN? Y N

FAVOR ONE SIDE WHEN CHEWING? Y N

TOOTH SENSITIVITY? If so, please check 1 or more:

☐ heat ☐ cold ☐ sweets ☐ biting pressure

OTHER .....

JOINT HISTORY

Clenching Teeth	Y N	Headaches	Y N	Jaw Joint Clicking	Y N	Grinding Teeth	Y N
Dizziness	Y N	Jaw Joint Soreness	Y N	Ear Pain	Y N	Pain Upon Opening	Y N
Ringing in Ears	Y N	Muscle Soreness	Y N	Explain			

I WISH THE FOLLOWING COULD BE DONE...

STRAIGHTEN FRONT TEETH ☐ upper ☐ lower

MOVE THE UPPER TEETH ☐ forward ☐ backward

MOVE THE MIDLINE OF THE TEETH ☐ upper ☐ lower

MOVE UPPER LIP ☐ forward ☐ backward

SHOW ☐ more / less ☐ ☐ teeth / gums ☐ WHEN I SMILE

MAKE THE UPPER FRONT TEETH ☐ longer ☐ shorter

MOVE THE LOWER TEETH ☐ forward ☐ backward

MOVE CHIN ☐ forward ☐ backward ☐ to center

MOVE LOWER LIP ☐ forward ☐ backward

REDUCE STRAIN IN ☐ lips / chin ☐ WHEN CLOSING LIPS

SIGNATURE (parent signature if patient is a minor) ..... **DATE** .....