

# Drs. Darrell E. and Andrew D. Schmidt, D.D.S.

Board Certified Specialists in Orthodontics and Dentofacial Orthopedics

(715) 365-1777

Rhinelanders • Minocqua • Eagle River

**CONFIDENTIAL**



Date \_\_\_\_\_

## Confidential Responsibility 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 _____

## Confidential Patient Information

Patient's Name _____			
Last                      First                      Middle			
Address _____			
Street                      City                      State                      Zip			
Home Phone _____	Birthdate _____	Social Security # _____	
If patient is a minor, give parent's or guardian's name _____			
Whom may we thank for referring you to our office? _____			

## Dental Insurance Information

Policy Holder's Name _____	Social Security # _____
Insurance Company _____	Group # _____ Union Local # _____
Insurance Co. Address _____	Insurance Co. Phone _____
Policy Holder's Employer _____	
Do you have dual coverage?    No <input type="checkbox"/> Yes <input type="checkbox"/> If yes:	
Policy Holder's Name _____	Social Security # _____
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 that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

# Personal Patient Information

I prefer to be called \_\_\_\_\_  
Hobbies/Interests/Sports \_\_\_\_\_  
Pets \_\_\_\_\_ Number of Siblings and ages \_\_\_\_\_  
Grade in School \_\_\_\_\_ Name of School \_\_\_\_\_

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

## PATIENT PROFILE

- yes no dk/u Does patient follow directions well?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive or self-conscious about teeth?

## MEDICAL HISTORY

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetès?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Problems of the immune system?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or liver problem?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Tired easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?
- yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

- yes no dk/u Skin disorder?
- yes no dk/u Does the patient eat a well-balanced diet?
- yes no dk/u Frequent headaches, colds or sore throats?
- yes no dk/u Eye, ear, nose or throat condition?
- yes no dk/u Hayfever, asthma, sinus trouble or hives?
- yes no dk/u Tonsil or adenoid conditions?

### Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin or other antibiotics
- yes no dk/u Sulfa drugs
- yes no dk/u Codeine or other narcotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Vinyl
- yes no dk/u Acrylic
- yes no dk/u Animals
- yes no dk/u Foods (specify) \_\_\_\_\_
- yes no dk/u Other substances (specify) \_\_\_\_\_

yes no dk/u 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 dk/u Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Does the patient chew or smoke tobacco?
- yes no dk/u Operations? Describe: \_\_\_\_\_
- \_\_\_\_\_
- yes no dk/u Hospitalized? Describe: \_\_\_\_\_
- \_\_\_\_\_
- yes no dk/u Other physical problems or symptoms? Describe: \_\_\_\_\_
- \_\_\_\_\_
- yes no dk/u Being treated by another health care professional?  
For: \_\_\_\_\_  
Date of most recent physical exam? \_\_\_\_\_
- Are there any other medical conditions that we should be aware of?  
\_\_\_\_\_

### GIRLS ONLY

- yes no dk/u Has the patient started her monthly periods?  
If so, approximately when? \_\_\_\_\_
- yes no dk/u Is the patient pregnant?

### FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems?  
If so, please explain.

- Bleeding disorders \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Metabolic disturbances \_\_\_\_\_
- Severe allergies \_\_\_\_\_
- Unusual dental problems \_\_\_\_\_
- Jaw size imbalance \_\_\_\_\_
- Any other family medical conditions that we should know about?  
\_\_\_\_\_

### DENTAL HISTORY

**Now or in the past, has the patient had:**

- yes no dk/u Started teething very early or late?
- yes no dk/u Primary (baby) teeth removed that were not loose?
- yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- yes no dk/u Jaw fractures, cysts or mouth infections?
- yes no dk/u "Dead teeth" or root canals treated?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Periodontal "gum problems"?
- yes no dk/u Food impaction between teeth?
- yes no dk/u Thumb, finger, or sucking habit? Until what age \_\_\_\_\_?
- yes no dk/u Abnormal swallowing habit (tongue thrusting)?
- yes no dk/u History of speech problems?
- yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?
- yes no dk/u Tooth grinding or jaw clenching?
- yes no dk/u Any pain in jaw or ringing in the ears?
- yes no dk/u Any pain or soreness in the muscles of the face or around the ears?
- yes no dk/u Difficulty encountered in chewing or jaw opening?
- yes no dk/u Aware of loose, broken or missing restorations (fillings)?
- yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
- yes no dk/u Concerned about spaced, crooked or protruding teeth?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u "Gum boils", frequent canker sores or cold sores?
- yes no dk/u Taking any forms of fluoride?
- yes no dk/u Any relative with similar tooth or jaw relationships?
- yes no dk/u Had periodontal (gum) treatment?
- yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?
- yes no dk/u Any serious trouble associated with any previous dental treatment?
- yes no dk/u Ever had a prior orthodontic examination or treatment?
- yes no dk/u Been under another dentist's care?  
Specialist \_\_\_\_\_  
Other \_\_\_\_\_

How often does your child brush: \_\_\_\_\_ floss: \_\_\_\_\_

What is your primary concern? Why are you here? \_\_\_\_\_

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: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Parent or Guardian)

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Dental staff member)

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