DYLAN SCHNEIDER, DDS, MS, LLC
ORTHODONTICS

PATIENT FORMS – ADULT

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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)

Dr./Mr. Mrs./Ms. _____ Age: _____ Date of Birth: ____/____/____
First Last M.I.
Home Address: _____ City: _____ Zip: _____ Phone: (____) _____

Mobile/Cell Phone: (____) _____ Email Address: _____

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

Name of Dentist: _____ Address: _____

How long have you been a patient at above: _____ Date of Last Dental Check-up: _____

Referred By: ☐ Friend: _____ ☐ Dentist ☐ Online Website ☐ Other: _____

Your marital status: ☐ Single ☐ Married ☐ Widow(er) ☐ Divorced

Have you had any previous orthodontic treatment or orthodontic consultations? ☐ Yes ☐ No If yes, when? _____

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

What is/are your main concern(s) about your teeth? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ___ Zip: _____ Phone: (____) _____

Date of Birth: ____/____/____ SSN: ____-____-____

Employer: _____ Address: _____ Phone: (____) _____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Do you or billing party have Orthodontic Insurance? ☐ Yes ☐ No ☐ Not Sure

If yes, Name of Subscriber: _____ Date of Birth: ____/____/____ SSN: ____-____-____

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

Name of Subscriber (Secondary): _____ Date of Birth: ____/____/____ SSN: ____-____-____

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

FAMILY INFORMATION

Have any family members been previously treated at our offices: ☐ Yes ☐ No

Name: _____ Dates: _____ Office: _____

Name: _____ Dates: _____ Office: _____

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

PATIENT MEDICAL HISTORY

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

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain: _____

_____

	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, please list: _____

_____

	Yes	No
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you 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) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following:

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
Aids or HIV Infections	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐

	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐

Other: _____

PATIENT DENTAL HISTORY

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

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

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: