Schmidtke Orthodontics

Dr. Gilpatrick Schmidtke, DDS, MS

Practice Limited to Orthodontics

Patient Information

Patient's Birth Name ______________________ Perfers to be called (Nickname) __________

Patient's Address ______________________ ________ D.O.B. ___/___/___ Today's Date ___/___/___

Street, City, State, Zip

School ______________________ Grade _____ Siblings: _______ Brothers _______ Sisters _______

Hobbies, Sports, Pastimes ______________________

Whom may we thank for referring you to our office? ______________________

Responsible Party Information

Father / Husband / or Self Name ______________________ E-mail Address ______________________

Address ______________________ Phone ______________________

Street, City, State, Zip

Cell Phone ______________________

Employer ______________________ Occupation ______________________

SS# ______________________ Work Phone ______________________

Mother / Wife / or Self Name ______________________ E-mail Address ______________________

Address ______________________ Phone ______________________

Street, City, State, Zip

Cell Phone ______________________

Employer ______________________ Occupation ______________________

SS# ______________________ Work Phone ______________________

Person or persons responsible for this account ______________________

For those patients who forego our courtesy discount for payment in full, Schmidtke Orthodontics provides in-house financing subjedt to a credit analysis. Please sign for authorization ______________________.

Insurance Information- Dental Insurance Only

Do you have orthodontic insurance? ☐ Yes ☐ No

Primary Insurance

Policy Holder's Name (as it appears on card) ______________________ D.O.B. ___/___/___ Member ID No. ______________

Insurance Company ______________________ Insurance Phone ______________ Group / Policy No. __________

Secondary Insurance

Policy Holder's Name (as it appears on card) ______________________ D.O.B. ___/___/___ Member ID No. ______________

Insurance Company ______________________ Insurance Phone ______________ Group / Policy No. __________

Medical and Dental History

Patient's Dentist ______________________ City ______________

Patient's Physician ______________________ City ______________

Is the patient under a physician's care now? _____ If so, what? ______________________ Girls: Has mensus begun? _____

Does the patient routinely take any medication before dental procedures? _____ If so, what? ______________________

Height _____ Weight ______ Any recent growth spurts? ______________________

Please indicate any history of the following:

- ☐ Mouth Breathing
- ☐ Thumb or Finger Sucking
- ☐ Speech Therapy
- ☐ Surgery: ______________________
- ☐ Rheumatic Fever
- ☐ Heart Condition (Murmur, etc.)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Blood Disorder
- ☐ Allergies
- ☐ Prosthesis (Artificial hip, etc.)

Is there any other information about the patient's health which should be known? ______________________

____

Have any of the patient's teeth ever been injured or extracted? Explain ______________________

____

How would the patient's attitude toward orthodontic treatment be described? ______________________

____

Has there been any previous orthodontic treatment or consultation other than our office? ______________________

____

I verify that the information provided is accurate

______________________ Date ___/___/___

Patient / Parent / Guardian