Schmidtke Orthodontics

Practice Limited to Orthodontics

Dr. Gilpatrick Schmidtke, DDS, MS

Patient Information

Patient's Last Name _____ First Name _____ Middle Initial _____

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____ I prefer to be called _____

Birth date _____ Sex: ☐ Male ☐ Female

Martial Status Single Married Separated Divorced Widowed

Home Address _____ City / State / Zip _____

Cell Phone ( ) _____ Home Phone ( ) _____ Work Phone ( ) _____

Email Address _____ Occupation _____ Employer _____

Spouse or closest relative's name(s) _____

Relationship to patient _____ Cell phone _____

Dentist

Patient's Dentist _____ Address / City / State _____ Last Seen _____

Other dentist/dental specialists now being seen: Name _____ City / State _____

Physician

Patient's Physician _____ City / State _____

General Information

What concerns do you have about your teeth _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? _____ Please describe: _____

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

Dental Insurance

Primary Policy Holder's Name (as it appears on card) _____ D.O.B. ___/___/___

Social Security # _____ - _____ - _____ Relationship to Patient _____

Address and Phone (if not listed above) _____

Employer _____ Insurance Company _____

Group # _____ ID No. _____ Phone # _____

Secondary Policy Holder's Name (as it appears on card) _____ D.O.B. ___/___/___

Social Security # _____ - _____ - _____ Relationship to Patient _____

Address and Phone (if not listed above) _____

Employer _____ Insurance Company _____

Group # _____ ID No. _____ Phone # _____

Patient Health Information

Have you ever taken any medications to strengthen your bones? Please describe: _____

Do you take antibiotic pre-medications before any dental procedures ☐ Yes ☐ No

Have you noticed any changes in your face or jaws? _____

How often do you floss? _____

Women: Are you pregnant ☐ Yes ☐ No

Family Medical History

Unusual dental problems _____

Jaw size imbalance _____

Medical History

Now or in the past, have you had:

☐ Yes ☐ No Birth defects or hereditary problems?
☐ Yes ☐ No Bone fractures, or major injuries?
☐ Yes ☐ No Any injuries to face, head, neck?
☐ Yes ☐ No Arthritis or joint problems?
☐ Yes ☐ No History of Osteoporosis?
☐ Yes ☐ No AIDS or HIV positive?
☐ Yes ☐ No Seizures, fainting spells, neurologic problems?
☐ Yes ☐ No Mental health disturbance or depression?
☐ Yes ☐ No History of eating disorder (anorexia, bulimia)?
☐ Yes ☐ No Excessive bleeding or bruising, anemia?
☐ Yes ☐ No Heart defects, heart murmur, rheumatic heart disease?
☐ Yes ☐ No Frequent headaches or migraines?
☐ Yes ☐ No Frequent ear infections, colds, throat infections?
☐ Yes ☐ No Asthma, sinus problems, hay fever?
☐ Yes ☐ No Tonsil or adenoid condition?

Have you had allergies or reactions to any of the following:

☐ Yes ☐ No Latex (gloves, balloons)
☐ Yes ☐ No Ibuprofen (Motrin,Advil)
☐ Yes ☐ No Penicillin
☐ Yes ☐ No Other antibiotics
☐ Yes ☐ No Metals (jewelry, clothing snaps)
☐ Yes ☐ No Acrylics
☐ Yes ☐ No Other substances

Dental History

Now or in the past, have you had:

☐ Yes ☐ No Permanent or extra (supernumerary)teeth removed?
☐ Yes ☐ No Supernumerary (extra) or congenitally missing teeth?
☐ Yes ☐ No Chipped or injured primary or permanent teeth?
☐ Yes ☐ No Any sensitive or sore teeth?
☐ Yes ☐ No Bleeding gums, bad taste or mouth odor?
☐ Yes ☐ No Jaw fractures, cysts, infections?
☐ Yes ☐ No Any teeth treated with root canals or pulpotomies?
☐ Yes ☐ No Frequent canker sores or cold sores?
☐ Yes ☐ No History of speech problems?
☐ Yes ☐ No Difficulty breathing through nose?
☐ Yes ☐ No Food impaction between the teeth?
☐ Yes ☐ No Mouth breathing habit or snoring at night?
☐ Yes ☐ No Frequent oral habit (sucking finger, chewing pen, etc.)?
☐ Yes ☐ No Teeth causing irritation to lip, cheek or gums?
☐ Yes ☐ No Abnormal swallowing (tongue thrust)?
☐ Yes ☐ No Tooth grinding or clenching?
☐ Yes ☐ No Clicking, locking in jaw joints?
☐ Yes ☐ No Soreness in jaw muscles or face muscles?
☐ Yes ☐ No Ringing in ears, difficulty in chewing?
☐ Yes ☐ No Have you ever been treated for "TMJ" or TMD" problems
☐ Yes ☐ No Any broken or missing fillings?
☐ Yes ☐ No Any serious trouble associated with previous dental treatment
☐ Yes ☐ No Have you ever been diagnosed with gum disease or pyorrhea?
☐ Yes ☐ No Have you ever had an orthodontic consultation or treatment before now

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company

Signature _____ Date _____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____