# WELCOME TO DR  SCHECHTMAN'S OFFICE

Today's Date_______ Nick Name:__________
Patient's Name:_________________________
Patient's Birthday__/__/__ Age___  M  F
School:_______________ Grade:_________
Hobbies:______________________________
Patient's Home# (____)________________
Patient's Home Address:___________________
___________________________ # years here?___
City___________________ Zip__________

Who is accompanying the patient today?
Name:______________ Relation:__________
Do you have legal custody of the patient? Y N
Referred by:___________________________
Brothers or sisters:_____________________
General Dentist:___________ Last visit:_____
Dentist's Phone #______________________
Relative or Friend not living with you:
Name:________________ Phone:__________

Who is responsible for account?____________ ______________

Marital Status:  [ ]Single  [ ]Married  [ ]Partnered  [ ] Widowed  [ ] Divorced  [ ]Separated

[ ]Father [ ]Step Father []Guardian
Name:______________________ DOB___/___/___
Address: (if different than Patient)
_____________________________________________
_____________________________________________
SS#:______-_____-______ DL#___________________
WK#(___)___________Ext:______Hm#:(___)_________
Employer:___________________Cell#:(___)___________
Occupation:__________________ How long there?_____
Employer's Address:______________________________
City____________________State______Zip_________

[ ]Mother [ ]Step Mother []Guardian
Name:_______________________DOB___/___/___
Address: (if different than Patient)
_____________________________________________
_____________________________________________
SS#:______-_____-______ DL#___________________
WK#(___)___________Ext:______Hm#:(___)_________
Employer:___________________Cell#:(___)___________
Occupation:__________________ How long there?_____
Employer's Address:______________________________
City____________________State______Zip_________

If you have Orthodontic Insurance Coverage please fill out:
Insurance Co. Name:____________________________
Insurance Address:______________________________
City_____________________State_____Zip_________
Insurance Phone:(____)___________________________
Group#(Plan, Local, or Policy#):_____________________

If you have Orthodontic Insurance Coverage please fill out:
Insurance Co. Name:____________________________
Insurance Address:______________________________
City_____________________State_____Zip_________
Insurance Phone:(____)___________________________
Group#(Plan, Local, or Policy#):_____________________

## Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If Dr. Schechtman's office accepts the insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize Dr. Schechtman to release all information necessary to to secure the payment of benefits.. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian ________________________________Date_________

# Medical History

Do you have a Personal Physician? Y N
Physician's Name______________________________________
Phone #:_______________________Date of last visit__________

**Your current physical health is: [] Good [] Fair [] Poor**

Are you currently under the care of a physician? Y N
Please explain:__________________________________
Do you smoke or use tobacco in any form ? Y N
Have you had any metal rods, pins or implants? Y N
Are you taking any prescription / over the counter drugs? Y N
Please List:____________________________________
Have you ever taken Phen-fen? Y N
If so, When?___________________________________
For Women: Are you taking birth control pills? Y N
Are you pregnant? Weeks #:________ Y N
Are you nursing? Y N

**Have you ever had any of the following diseases or medical problems**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Hepatitis |
| Y | N | AIDS | Y | N | Herpes/Fever Blisters |
| Y | N | Alcohol/Drug Abuse | Y | N | High Blood Pressure |
| Y | N | Anemia | Y | N | HIV |
| Y | N | Arthritis | Y | N | Hospitalized for Any Reason |
| Y | N | Artificial Bones/Joints | Y | N | Kidney Problems |
| Y | N | Artificial Valves | Y | N | Liver Disease |
| Y | N | Asthma | Y | N | Low Blood Pressure |
| Y | N | Blood Transfusion | Y | N | Mitral Valve Prolapse |
| Y | N | Cancer/Chemotherapy | Y | N | Pacemaker |
| Y | N | Colitis | Y | N | Psychiatric Problems |
| Y | N | Congenital Heart Defect | Y | N | Radiation Treatment |
| Y | N | Diabetes | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Difficulty Breathing | Y | N | Seizures |
| Y | N | Emphysema | Y | N | Shingles |
| Y | N | Epilepsy | Y | N | Sickle Cell Disease/Traits |
| Y | N | Fainting Spells | Y | N | Sinus Problems |
| Y | N | Frequent Headaches | Y | N | Stroke |
| Y | N | Glaucoma | Y | N | Thyroid Problems |
| Y | N | Hay fever | Y | N | Tuberculosis (TB) |
| Y | N | Heart Attack/Surgery | Y | N | Ulcers |
| Y | N | Heart Murmur | Y | N | Venereal Disease |
| Y | N | Hemophilia | | | |

Please list any serious medical condition(s) that you have ever had:
_____________________________________________
_____________________________________________

Are you allergic to any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Latex |
| Y | N | Codeine | Y | N | Penicillin |
| Y | N | Dental Anesthetics | Y | N | Tetracycline |
| Y | N | Erythromycin | Y | N | Other |
| Y | N | Jewelry / Metal | | | |

Please list any other drugs / materials that you are allergic to:

# Dental History

What are the main concerns that you would like orthodontics to accomplish:
_____________________________________________
_____________________________________________

Have you ever had or been evaluated for Orthodontic treatment? Y N
Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMD/TMJ) Y N
Your current dental health is:
[] Good [] Fair [] Poor
Do you still have wisdom teeth? Y N
Have you ever had an injury to your: Y N
Mouth Teeth Chin
Do you have any speech problems? Y N
_____________________________________________
Do you generally breathe through your mouth? Y N
While Awake? Y N
While Asleep? Y N
Do you have any missing or extra permanent teeth? Y N

Are you happy with the way your smile looks? Y N

If not, what would you change?_______________
_____________________________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/ or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature___________________________Date__________

OFFICE USE ONLY - OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials:___________________ Date:_________
Doctor's Comments:_________________________________
_____________________________________________
_____________________________________________
_____________________________________________