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t (530) 842-5320
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R. SCOTT **SCHALO** D.D.S., M.S.
PERSONALIZED ORTHODONTICS

The following information is requested in order for us to best diagnose and treat your orthodontic problem. This information, which is important for our records and your health, is confidential. Please complete the following as completely as possible. Circle or check the appropriate response where indicated. Thank you!

Date: ______________________________

PATIENT INFORMATION:

Patient's name: ______________________________ Nickname: __________ Age: _____ Sex: _____
First M.I. Last

Date of Birth: ____________ Email: ____________________ Home Phone: ____________________

Residence: ______________________________ Cell Phone: ____________________
Street City ST ZIP

Mailing Address: (if different) ______________________________

Patient's Dentist: ____________________ Physician: ______________________________

Whom may we thank for referring you to our office: ______________________________

Has any other member of your family been treated in our office? ❑ Yes ❑ No and Name(s) ____________________

Sibling name(s) and Birthdate(s) ______________________________

Closest relative not living with you ____________________ Relationship: ____________________

Residence: ______________________________ Phone: ____________________
Street City ST ZIP

PATIENT UNDER 18 YEARS OLD:

Father's Name: ____________________ SS# ____________________ Birthdate: __________

Residence: ______________________________ Home Phone: ____________________
Street City ST ZIP

Email: ______________________________ Cell Phone: ____________________

Mailing Address: (if different) ______________________________ DL# __________

Occupation: ____________________ Employer: ____________________ Work# __________

Work Address: ______________________________ How Long: __________

Mother's Name: ____________________ SS# ____________________ Birthdate: __________

Residence: ______________________________ Home Phone: ____________________
Street City ST ZIP

Email: ______________________________ Cell Phone: ____________________

Mailing Address: (if different) ______________________________ DL# __________

Occupation: ____________________ Employer: ____________________ Work# __________

Work Address: ______________________________ How Long: __________

Parent's Divorced: ❑ Yes ❑ No If yes, who has custody of the child? ______________________________

ADULT PATIENT:

SS#: ____________________ DL# ____________________

Occupation: ____________________ Employer: ____________________ Work# __________

Spouse's Name: ____________________ DL# ____________________ SS# __________

Occupation: ____________________ Employer: ____________________ Work# __________

DENTAL INSURANCE INFORMATION:

Do you have dental insurance? ❑ Yes ❑ No

Insurance Company: ____________________

Insureds Name: ____________________

Birthdate: ____________________

SS# ____________ Group# ____________

Employer: ____________________

Do you have additional dental insurance? ❑ Yes ❑ No

Insurance Company: ____________________

Secondary Carrier: ____________________

Birthdate: ____________________

SS# ____________ Group# ____________

Employer: ____________________

MEDICAL HISTORY:

(Please Check) Has the patient ever had:

Arthritis	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Acquired Immune Deficiency Syndrome (AIDS)	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Hearing Disorder	❑ Yes ❑ No		
Blood Disease	❑ Yes ❑ No	Head or Face Injury	❑ Yes ❑ No		
Bone Disorders	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Human Immunodeficiency Virus (HIV Positive)	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Prolonged Bleeding	❑ Yes ❑ No		
Endocrine Problems	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No		

Please initial here if none of the above apply: ____________

Are there any problems with emotional or mental development? ❑ Yes ❑ No Other comments: ____________

____

Has the patient been under the care of a physician during the last two years, other than for routine examinations? ❑ Yes ❑ No

When? ____________ Condition: ____________

Has the patient ever had major surgery or been hospitalized? ❑ Yes ❑ No For what condition: ____________

Last date of physical examination: ____________ Given by: ____________

Have you ever taken Bisphosphonates (ex. Aredia, Fosamax) for Osteoporosis?: ❑ Yes ❑ No

List of drugs or medications now using: ____________

List any allergies or drug **sensitivities** (including metal or latex) ____________

Has a physician ever advised you of the need for antibiotics prior to general dental procedures, such as the cleaning of teeth? ❑ Yes ❑ No

Has the patient ever received medical treatment from an **allergist** or **ear, nose,** and **throat** specialist? ❑ Yes ❑ No

If yes, when? ____________ By whom? ____________

Nasal Surgery? ____________ Tonsils Removed? ______ Adenoids removed? _____ When? ______

Birth defects: ____________

Has the patient reached puberty? ❑ Yes ❑ No Females: Is there a chance that the patient is pregnant? ❑ Yes ❑ No

T.M.J. ("JAW JOINT") HISTORY:

(Please Check) **Has the Patient Ever Had:** ❑ Recurring pain in jaw joint, ear, or side of face? ❑ Frequent headaches? ❑ Clicking or popping in the jaw joint? ❑ Difficulty in opening or closing? ❑ Difficulty in chewing or swallowing?

DENTAL HISTORY:

Has the patient or parent had periodontal disease or pyorrhea? .... ❑ Yes ❑ No Comment: ____________

Have you been informed of missing teeth? .... ❑ Yes ❑ No Comment: ____________

Have any teeth been injured due to accidents or blows to the mouth? . ❑ Yes ❑ No Comment: ____________

Have there been any injuries to the head or jaws or face? .... ❑ Yes ❑ No Comment: ____________

Has the patient received or been requested to receive speech correction? ❑ Yes ❑ No Comment: ____________

Has the patient been known to:

- Clench teeth .... ❑ Yes ❑ No Comment: ____________
- Lip bite or sucking .... ❑ Yes ❑ No Comment: ____________
- Grind teeth .... ❑ Yes ❑ No Comment: ____________
- Tongue thrust .... ❑ Yes ❑ No Comment: ____________
- Suck thumb/finger(s) .... ❑ Yes ❑ No Comment: ____________
- Mouth breathe .... ❑ Yes ❑ No Comment: ____________

Has the patient had any unusual dental experiences? .... ❑ Yes ❑ No Comment: ____________

Approximate date of last dental check-up ____________ Were the patients teeth cleaned? ❑ Yes ❑ No

Has the patient had a previous orthodontic consultation? ❑ Yes ❑ No Treatment? ❑ Yes ❑ No

What is the patients interest in orthodontic treatment? ____________

❑ Wants treatment ❑ Treatment, if necessary ❑ Unwilling, but agrees ❑ Will not cooperate

In your own words, what is your main concern(s) ____________

____

Does the patient have any condition, problem or disease not listed previously of which you feel we should be aware?

____

I understand that where helpful, a credit inquiry may be obtained.

____
Signature (Patient, or parent, if patient is a minor)

____
Date