Welcome

Our goal at Dr. Rick Schuberth's office is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

Confidential Patient Information

Today's Date_____/_____/_____

Patient's Name _____
Last First Middle Initial

Nicknames_____ Gender: Male Female (circle one)

D.O.B.: _____/_____/_____ Age_____

Home Address: _____
Apt/Condo#

_____
City State Zip code

Cell#: _____ Home#: _____

Email Address: _____

Emergency Contact: _____ Phone: _____
Other Family Members Seen By Us: _____

Financial Information

Marital status: _____

How Long at Current Address _____ Own Rent Other (circle one)
Employer: _____Occupation: _____
How Long at Current Job: _____
If married: Spouse's name: _____Spouse's Employer: _____

How long at current job? _____

I understand that credit bureau reports may be obtained.

Signature: _____ Printed Name: _____ Date: _____

Co-Signer: _____Printed Name: _____Date: _____

Patient's Medical History

Your current physical health is: □ Good □Fair □Poor

Are you currently under the care of a physician? □ Yes □No
Please explain: _____
Physician: _____
Phone: _____ Date of last visit : _____

Are you taking any prescription/over-the-counter medications? □
Please list:
_____
_____

Circle YES or NO if applicable now or in the past:

YES	NO	Heart Attack/Stroke
YES	NO	Heart Murmur/MVP/Damaged Heart Valves
YES	NO	Congenital Heart Defect/Heart Surgery
YES	NO	High /Low Blood Pressure
YES	NO	Necessary Premedication
YES	NO	Pacemaker
YES	NO	Auto Immune Diseases
YES	NO	Shingles
YES	NO	Mononucleosis
YES	NO	Arthritis
YES	NO	Sickle Cell Disease/Traits
YES	NO	Ulcers/Colitis
YES	NO	Rheumatic/Scarlet Fever
YES	NO	Fever Blisters/Herpes
YES	NO	Abnormal Bleeding
YES	NO	Hemophilia
YES	NO	Anemia
YES	NO	Hepatitis/HIV/AIDS
YES	NO	Tuberculosis (TB)
YES	NO	Liver Problems
YES	NO	Kidney Problems
YES	NO	Asthma
YES	NO	Difficulty Breathing
YES	NO	Emphysema
YES	NO	Diabetes
YES	NO	Glaucoma
YES	NO	Sinus Problems
YES	NO	Severe Frequent Headaches
YES	NO	Epilepsy/Seizures/Fainting/Convulsions
YES	NO	Artificial Bones/Joints/ Valves
YES	NO	Cancer/Chemotherapy/Radiation
YES	NO	Handicaps/Disabilities
YES	NO	Hearing Impairment
YES	NO	Pregnancy Expected Due date: _____
YES	NO	Any Hospital Stays
YES	NO	Any Operations
YES	NO	ADD/ADHD
YES	NO	Psychiatric Problems
YES	NO	Drug/Alcohol Abuse

Any Medical/Dental condition NOT mentioned above: _____
_____
_____
If YES to any of the above questions, please explain: _____
_____
_____
_____

Are you allergic to any of the following ?

YES	NO	Latex
YES	NO	Aspirin
YES	NO	Any Metals/Plastics
YES	NO	Codeine
YES	NO	Dental Anesthetics
YES	NO	Erythromycin
YES	NO	Penicillin
YES	NO	Tetracycline

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

Dental History

General Dentist: _____

Last Visit: _____

What are the main concerns that you would like orthodontics to accomplish?
_____
_____

Ever been evaluated for orthodontic treatment? Yes No
Any serious/difficult problem associated with any previous dental work? Yes No
Any injuries to the face, mouth, teeth, or chin? □ Yes No
Adenoids or tonsils been removed? Yes No
Any missing or extra teeth? Yes No
Tongue thrust? Yes No
Thumb/finger sucking habit? Yes No
Any pain/discomfort in the jaw joint?
(TMJ / TMD or Bruxism) Yes No
Grind your teeth or clench your jaw? Yes No
Brush daily? □ Yes No
Floss daily? □ Yes No
Current dental health is: Good □Fair □ Poor (Circle)
Do you like your smile? □ Yes No
Any speech problems? Yes No
Mouth breather? □ Yes
No

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 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 service that I may need during diagnosis and treatment with my informed consent.

Signature: _____

Date: _____