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: (Circle One) Married Divorced Single Widowed

How Long at Current Address _____ **(Circle One)** Own Rent Other
Employer: _____Occupation: _____
How Long at Current Job: _____
If married: Spouse's name: _____ **Spouse's DOB:** _____

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	Osteoporosis/Osteopenia
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
Smoke or use tobacco in any form? □ 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: _____