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: _____ School: _____ Grade Level: _____

Birthdate: _____/_____/_____ Age_____ Gender: Male Female (circle one)

Home Address: _____

_____

City State Zip code

Cell#: _____ Home#: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Legal Guardian or Custodial Parent: _____ Relationship to Patient: _____

Other Family Members Seen By Us: _____

Financial Information

Parental Marital status: _____

Responsible Party (#1) Name: _____ Relationship to Patient: _____

Name: _____ DOB: _____ Phone: _____

Address: _____

How Long at Current Address _____ Own Rent Other (circle one)

Employer: _____Occupation: _____

How Long at Current Job: _____

Responsible Party (#2) Name: _____ Relationship to Patient: _____

Name: _____ DOB: _____ Phone: _____

Address: _____

How Long at Current Address _____ Own Rent Other (circle one)

Employer: _____Occupation: _____

How Long at Current Job: _____

I understand that credit bureau reports may be obtained.

Signature: _____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 :_____

Is your child 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
Ever had a serious/difficult problem associated with any previous dental work? Yes No
Any injuries to the face, mouth, teeth, or chin Yes No
List any musical instruments played: _____
Adenoids or tonsils removed? Yes No
Missing or extra teeth? Yes No
Tongue thrust present Yes No
Thumb/finger sucking habit? Yes No
Ever, experienced pain/discomfort in the jaw joint? (TMJ / TMD or Bruxism) □ Yes No
Grind your teeth or clench your jaw? Yes No
Do you 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 breathing? □ Yes

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 child's cmedical 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: _____