Schuster Family Orthodontics

Patient Information:

Patient Name (Last/Middle/First):_____ Gender (M/F):_____
Address:_____ City:_____ State:_____ Zip:____
Phone # (Home):_____ Alternate Phone#:_____
Marital Status: __Single __Married __Child __Other Date of Birth:___/___/___
F/T Student: Y/N School:_____
Employer:_____ Employer Phone:_____
Whom may we thank for referring you?_____
Emergency Contact :_____ Phone#:_____
Relationship:_____
EMAIL:_____ (we will not share your email).

Responsible Party:

Name:_____ Relationship to Patient:_____
Address:_____ Home Phone:_____
Birthdate:_____Employer:_____Work :_____
May we call you at work? Y/N

Primary Insurance:

Who is responsible for this account?_____ Relationship to Patient:_____
Subscriber's Name:_____ Date of Birth:___/___/___
SS#:____-____-____
Address:_____ City:_____State:_____ Zip:_____
Phone #:_____ Alternate Phone:_____
Marital Status: __Single __Married __Divorced
Employer:_____Employer Phone:_____
Employer Address:_____
Insurance Company:_____ Address:_____
Insurance Co. Phone#:_____Group#:_____ID#:_____
Is patient covered by additional insurance? ___Yes ___No

Secondary Insurance:

Subscriber's Name:_____ Date of Birth:___/___/___
SS#:____-____-____
Address:_____City:_____State:_____ Zip:_____
Phone #:_____ Alternate Phone:_____
Insurance Company:_____
Insurance Co. Phone #:_____Group#:_____ID #:_____

Dental Patient Information:

Name and Location of Dentist:_____ Date of Last Exam:_____

Do your gums bleed while brushing or flossing? __Y __N
Are your teeth sensitive to hot or cold liquids? __Y __N
Are your teeth sensitive to sweet or sour ? __Y __N
Do you feel pain in any of your teeth? __Y __N
Do you have any sores or lumps in your mouth? __Y __N
Any jaw clicking/popping? __Y __N
Any jaw pain? __Y __N
Do you have difficulty opening or closing? __Y __N
Any difficulty chewing? __Y __N

Do you clench or grind your teeth? __Y __N
Do you bite your lips or cheeks frequently? __Y __N
Have you had any extractions in the past? __Y __N
Have you had any orthodontic treatment? __Y __N
Have you had any head/neck injuries? __Y __N

Medical information:

Physician's Name:_____ Last visit:_____

Please check all that apply:

__Abnormal bleeding
__Allergies to any Drugs
__Allergies to any Latex/Metals
__Allergies to any Plastics
__Anemia/Radiation Treatment
__Artificial Bone/Joints/Valves
__Asthma
__Arthritis
__Blood Transfusion
__Cancer/Chemotherapy
__Congenital Heart Defects
__Diabetes
__Tuberculosis
__Difficulty Breathing
__Drug/Alcohol Abuse
__Emphysema
__Glaucoma
__Epilepsy/Seizures/Fainting
__Fever Blisters/Herpes

__Heart Murmur
__Heart Surgery/ Pacemaker
__Hemophilia
__High/Low Blood Pressure
__HIV/AIDS
__Hospitalization
__Kidney Problems
__Mitral Valve Problems
__Psychiatric Problems
__Rheumatic/Scarlet Fever
__Shingles
__Sinus Problems
__Severe/Frequent Headaches
__Heart Attack
__Ulcers/Colitis
__Venereal Disease
Are you pregnant __Y __N

Please discuss any medical problems you/your child has/had:

_____

_____

_____

I understand that this information is correct and will be held in confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of patient/parent or guardian Date: