Jeffrey A. Schur, DDS MSD **Patient Information—Adults**

Please complete the following information as accurately as possible. All information is confidential as per HIPAA Rules.

Patient Information

Name: Title _____ Last ____________________________ First ______________________ Middle _________________ Suffix _______

Preferred Name __________________________________ Gender ____M ____F Date of Birth: ___/___/___

Home Address with zip ____

Employer & Work Address ____

Phones: Home (______)_____________________ Office (______)_____________________ Cell (______)____________________

Orthodontic Insurance Company ____ Policy # ______________________________

S.S. # ____________________________________ Email Address ____

Would you like automated email appointment reminders and online access to your appointment & account information? ____Y ____N

Spouse Information

Name: Title _____ Last ____________________________ First ______________________ Middle _________________ Suffix _______

Preferred Name ________________________ Date of Birth: ___/___/___ S.S. # __________________________________

Employer & Work Address ____

Phones: Office (______)_____________________ Cell (______)_____________________

Orthodontic Insurance Company ____ Policy # ______________________________

Health Information

Dentist ____ How many years? _________ Date of last visit ___________________

Physician ____ How many years? _________ Date of last visit ___________________

Other Health Care practitioners seen ____

Medications taken over the past 12 months ____

Allergies: Drugs ____ Other ____________________________________

Please tell us about your reason for seeing Doctor Schur, including your impressions of your orthodontic needs and any concerns you might have: ____

____

Please mark any that apply, <u>past or present</u>:

Dental Health History

Have you had an orthodontic examination before?	_______	Have you been referred to other specialists?	_______
Are you happy with the function of your teeth?	_______	Are you happy with the appearance of your teeth?	_______
Are you happy with how your bite feels?	_______	Jaw or jaw joint pain?	_______
TMJ (jaw joint) or TMD problems?	_______	Popping of the jaws or jaw joints?	_______
Frequent headaches?	_______	Jaw locking open or closed?	_______
Previous orthodontic treatment?	_______	Injury to teeth or jaws?	_______
Were your wisdom teeth extracted?	_______	Bleeding gums, gum recession , or gum disease?	_______
Is any dental treatment planned or needed?	_______	Are there any persistent sores in your mouth?	_______
Do you clench or grind your teeth?	_______	How frequently do you have your teeth cleaned?	____________

Medical Health History

Do you take/need antibiotics before dental treatment?	_______	Heart problem/condition?	_______
Blood pressure problem?	_______	Heart murmur or valve problem?	_______
Artificial heart valve?	_______	Growth, tumor, or cysts?	_______
Shunts, implants, or prosthetics?	_______	Blood problems?	_______
Lung, breathing, respiratory problems?	_______	Digestive, stomach, intestinal problems?	_______
Bone, joint, back, or neck problems?	_______	Joint replacement?	_______
Arthritis?	_______	Do you use tobacco?	_______
Diabetes?	_______	Kidney or urinary problems?	_______
Gland problems?	_______	Cancer?	_______
Hepatitis?	_______	HIV/AIDS?	_______
Tuberculosis or other infectious disease?	_______	Herpes/cold sores/STD's?	_______
Immune system problems?	_______	Liver disease or jaundice?	_______
Seizures or other nervous system problems?	_______	Substance abuse?	_______
Women: Are you pregnant?	_______	Oral contraceptives or hormone therapy?	_______

Any other disease, condition, or behavioral problems or issues? ____

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____________________________________ __________________ _____________

Parent/Guardian Signature Date Doctor's Initials