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

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

Patient Information
Name: Last ________________________________ First ______________________ Middle ________________ Gender ___M ___F
Preferred Name _____________________ Birth date: ___/___/___ Age_______ Siblings/age _________________________________

Father's Information
Name: ____ 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

Mother's Information
Name: ____ 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

Parental/Marital/Guardian information: ____

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 Dr. Schur, including your impressions of your child's 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? ____
____

______________________________ ________________ ____________
Parent/Guardian Signature Date Doctor's Initials