SCHUSTER FAMILY ORTHODONTICS
Let Our Family Take Care of Yours

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:_____
*How did you hear about our office?*_____
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 #:_____

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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 list any medical problems you/your child has/had:

_____

Please list any medication allergies:_____

Please list any medications you are currently taking:_____

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.

_____
Signature of patient/parent or guardian Date:

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What to expect during your initial consultation

In addition to an initial exam, Dr. Schuster likes to view a **Panoramic x-ray** to evaluate the health of the roots and bone surrounding the teeth.

If you have not had your dental office send over a recent panoramic x-ray, we will take one at no charge.

Dr. Schuster also likes to take **photographs** to allow her to demonstrate her findings and to measure changes to your teeth and gums over time.

These photos will be stored in your personal file, we will not display them anywhere else.

Because all images are digital, we can send them to you and/or your dentist if you would like.

_____ Please send my/my child's x-rays and photos to me. My email address is:
Initial

_____

_____ Please send my/my child's x-rays and photos to my general dentist.
Initial

_____
Dentist name and location

- -

I consent to electronic transfer of my x-rays and photos via email:

_____
Patient name

_____ _____
Name of patient/parent/guardian Signature of patient/parent/guardian

If you do not want your images shared, you may leave the above portion blank