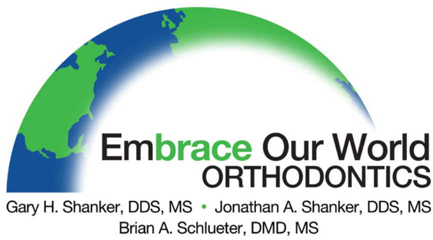

Gary H. Shanker, D.D.S., M.S.
Jonathan A. Shanker, D.D.S., M.S.
Brian A. Schlueter, D.M.D., M.S.
12111 Tesson Ferry Professional Center
St. Louis, MO 63128
(314) 842-4105

CONFIDENTIAL
Patient is under 18 years of Age

Date____________________ Computer Number___________________

Patient's Last Name: ___________________________________First Name:_____________________________Middle Initial:_______________

Birth Date:______/_______/_______Age:__________Sex: M / F I prefer to be called: ____________________________________

Patient's Address____

City:____________________________________State/Province:__________________Zip:____________________

Home Phone:____Cell:____

School:____Grade:________________________

Any family member or friends treated here:____

Mother's Name:____

Work Phone:____Cell Phone:____

E-Mail Address____

Address (if different): ____

Occupation:____S.S.N.:____

Father's Name:____

Address (if different): ____

Work Phone:____Cell Phone:____

E-Mail Address____

Occupation:____S.S.N.____

Name of Patient's Dentist:____

Date last seen:_____________________________Reason:____

Name of Patient's Physician:____Office Phone:______________________________

Date last seen:_____________________________Reason:____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:____

Who is financially responsible for this account?

Last Name:________________________________First Name:____Middle Initial:__________________

Address(if different):____

City:__________________________State/Province:______________Zip_______________Phone:_________________________________

Work Phone:___________________________________S.S.N.:___________________________or ID number:_______________________________

Birth Date:_________/___________/__________

Do you have Dental Insurance?________________

THE FOLLOWING QUESTIONS MARK YES OR NO. THE ANSWERS ARE FOR OFFICE RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Patient Profile

___yes ___no Does patient follow directions well?

___yes ___no Does patient have a learning disability?

___yes ___no Does patient brush teeth conscientiously?

___yes ___no Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, have you had:

___yes ___no Rheumatoid or arthritic conditions?

___yes ___no Endocrine or Thyroid problems?

___yes ___no Diabetes?

___yes ___no Cancer, tumor, radiation treatment or chemotherapy?

___yes ___no Immune system problems?

___yes ___no AIDS or HIV?

___yes ___no Hepatitis, jaundice, or liver problems?

___yes ___no Mental health disturbances or depressions?

___yes ___no Vision, hearing, tasting, or speech difficulties?

___yes ___no History of eating disorder (anorexia, bulimia)?

___yes ___no High or low blood pressure? (Circle one)

___yes ___no Heart problems?

___yes ___no Skin disorder?

___yes ___no Frequent headaches?

___yes ___no Eye, ear, nose, or throat condition?

___yes ___no Hay fever, asthma, sinus trouble?

___yes ___no Tonsil, or adenoid condition?

___yes___no Snoring?

___yes___no Does your child wear a C-PAP or oral appliance to help with breathing?

___yes___no Do you feel your child gets good sleep at night?

___yes___no Do you feel your child has a lack of attention and/or hyperactivity?

___yes___no Does your child have night time bedwetting?

___yes___no Has your child been diagnosed with ADHD?

___yes ___no Osteoporosis?

Allergies or reactions to any of the following:

___yes ___no Local anesthetics

___yes ___no Aspirin

___yes ___no Ibuprofen

___yes ___no Penicillin or other antibiotics

___yes ___no Vinyl

___yes ___no Acrylic

___yes ___no Other Substances

___yes ___no Latex (gloves, balloons)

___yes ___no Codeine or other narcotics

___yes ___no Metals (jewelry, clothing snaps)

OTHER

___yes ___no Do you currently have or ever had a substance abuse problem?

___yes ___no Do you, or have you chewed or smoked Tobacco? If so, when?________________________________

___yes ___no Other physical problems or medical conditions?

____

____

MEDICATIONS

Have you ever taken Biphosphanate Drugs for Cancer, Osteoporosis or any other condition? _____yes_____no If yes, which one(s):

IV _____Aredia
_____Zometa
_____Other

ORAL_____Actinel
_____Boniva
_____Didronel
_____Skelid
_____Other

OTHER MEDICATION(S) TAKEN:

Medication_____________________taken for________________________

Medication_____________________taken for________________________

Medication_____________________taken for________________________

Medication_____________________taken for________________________

Do you ever take a Pre-Medication antibiotic before certain dental procedures? _____yes _____no

Continue from page 2,

DENTAL HISTORY

Now or in the past have you ever had?

___yes ___no _________date Supernumerary "extra" permanent teeth removed?

___yes ___no _________date Chipped or otherwise injured primary or permanent teeth?

___yes ___no _________date Teeth sensitive to hot, or cold: teeth throb or ache?

___yes ___no _________date Jaw fractures, cysts or mouth infections?

___yes ___no _________date Periodontal "gum problems"?

___yes ___no _________date History of speech problems?

___yes ___no _________date Mouth breathing habit?

___yes ___no _________date Tooth grinding or jaw clenching?

___yes ___no _________date Would you mind wearing braces?

___yes ___no _________date Any serious trouble with any previous dental treatment?

___yes ___no _________date Ever had an orthodontic evaluation or treatment? If yes, who provided the examination or ortho?

____

___yes ___no _________date Been under another specialist care (Periodontist, Endodontist, etc…)?

___yes ___no _________date Thumb, finger, or sucking habit? Age habit ceased?_____________________

___yes ___no _________date Tongue thrusting?

___yes ___no Has any relative ever had jaw surgery to correct their bite?

___yes ___no Does any relative have an under bite?

How often does your child brush? ___________________________Floss? _____________________________

What is your primary concern? Why are you here? ____

I have read and understood the above questions. I will not hold the orthodontist or any other member of his/her staff responsible for any errors or omissions that I have made in the completions of this form. If there are any changes later to this history record or medical/dental status, I will so inform the office. I also understand that in order to offer financial arrangements it is necessary to gather credit information.

Signed: ____Date signed: ______________________________
Parent or Guardian

HIPAA ACKNOWLEDGEMENT

I have been notified and I acknowledge the Notice of Privacy Practice for Drs. Gary and Jonathan Shanker and Dr. Brian Schlueter's office. I have been offered a copy to take with me.

____
Initials