



ROSS W. STRYKER, D.D.S., P.C. Specialist in Orthodontics for Children and Adults

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Patient Information

Today's Date _____		
Name: _____		Mr. / Mrs./Ms./Miss/Dr.
Birthdate: _____	Age: _____	SS # _____
Married/Single/Divorced/Widowed/Separated		
Home address: _____		City/State: _____ Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Email: _____		Best time and # to reach you at: _____
Employer: _____		How long there: _____ Occupation: _____
Employer address: _____		City/State: _____ Zip: _____
Who may we thank for referring you? _____		
Other family members seen by us: _____		
General dentist: _____		Last visit date: _____ Work to be done: Yes/ No
Name of Spouse: _____		Birthdate: _____ SS #: _____
Spouse's employer: _____		Work Phone: _____ How long there _____
Emergency contact (Relative or friend not living with you) Name: _____		Phone: _____

Orthodontic Insurance Information

Primary orthodontic insurance		
Insured's Name: _____		Relation _____ Birthdate: _____
Insurance Co. Name: _____		Phone number: _____
Address: _____		City/State: _____ Zip _____
Employer Name: _____		Group # _____ ID # _____
Secondary orthodontic insurance		
Insured's Name: _____		Relation _____ Birthdate: _____
Insurance Co. Name: _____		Phone number: _____
Address: _____		City/State: _____ Zip _____
Employer Name: _____		Group # _____ ID # _____
*Please give your insurance card(s) to the receptionist to run a photocopy.		

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Health History

Medical history: (please write in or circle your answer)

Your current physical health is: Good /Fair/Poor

Are you under the care of a physician? Yes/No Please explain _____

Are you taking any prescription/OTC drugs? Yes/No Please list each one: _____

For Women: Are you taking birth control pills? Yes/No Are you pregnant/nursing? Yes/No Week# _____

Are you allergic to any of the following? (Please circle)

Aspirin / Metals / Plastics / Codeine / Dental Anesthetics / Erythromycin / Latex / Penicillin / Tetracycline

Please list any other drugs/materials that you are allergic to: _____

Have you ever had any of the following diseases or medical problems? (Please circle any you have or had)

Abnormal bleeding / Anemia / Artificial bones, joints, valves / Asthma / Arthritis / Blood transfusion / Cancer / Chemotherapy / Congenital heart failure / Diabetes / Difficulty Breathing / Drug or Alcohol abuse / Emphysema / Epilepsy, seizures, Fainting / Fever blisters / Herpes / Glaucoma / Heart attack / Stroke / Heart Murmur / Heart Surgery/ Pacemaker / Hemophilia / Hepatitis/ High or low blood pressure / HIV+ / AIDS /Kidney problems / Mitral Valve Prolapsed / Psychiatric Problems / Radiation Treatment / Rheumatic or Scarlet fever/Headaches (severe or frequent) / Shingles / Sickle Cell Disease / Sinus problems / Tuberculosis (TB) / Ulcers / Colitis / Venereal disease

Please list any serious medical condition(s) or hospitalizations that you have ever had: _____

Dental History: (please write in or circle your answer)

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthodontic treatment? Yes/No

Have you ever had a serious/ difficult problem associated with any previous dental work? Yes/No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes/No

Your current dental health is: Good/Fair/Poor Do you brush your teeth daily? Yes/No

Do you like your smile? Yes/No Gums ever bleed? Yes/No Do you floss your teeth daily? Yes/ No

Have you had an injury to your: Mouth / Teeth / Chin Do you have any speech problems? Yes/No

Do you generally breathe through your mouth? Yes/No If yes, please circle: While Awake? / While Asleep?

Do you have any missing or extra permanent teeth? Yes/No

Have you ever taken Phen-Fen? (also known as Redux or Pondimin) Yes/no If yes, when? _____

Do you smoke or use tobacco in any form? Yes/No

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I need. I acknowledge that I have read and received a copy of the privacy consent form as provided by the office of Dr. Ross W. Stryker, DDS., P.C.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductibles that my insurance does not cover.

I understand, where appropriate, credit bureau reports may be obtained.

Signature of Patient

Date