Steven C. Maurstad, D.D.S.

Patient Information

Name: ____

Last First MI

Address: ____

Number and Street City State Zip code

M F

____

Home Phone Business Phone - Ext. Social Security Number Date of Birth Sex

cell phone______________________ e-mail___________________________

Responsible Party Information

Name: ____

Last First MI

Address: ____

Number and Street City State Zip code

____

Home Phone Business Phone - Ext. Social Security Number Date of Birth

Employer: ______________________________________ ______________

Employer Phone

Address: ____

Number and Street City State Zip code

Dental Insurance Company ______________________________________

Address: ____

Number and Street City State Zip code

______________________ ______________________

Group Number Insurance Company Phone Number

Secondary Dental Insurance Information

Employer: ______________________________________ ______________

Employer Phone

Address: ____

Number and Street City State Zip code

Dental Insurance Company: ______________________________________

Address: ____

Number and Street City State Zip code

______________________ ______________________

Group Number Insurance Company Phone Number

I learned of Dr. Maurstad's practice from: ______________________________

Person to contact in case of emergency

______________________ ______________ ______________

Name Daytime Phone Evening Phone

____

Signature of Patient or Guardian Date

Steven C. Maurstad, D.D.S.

Medical History Questions

How would you describe your current state of health? ______________________

____

Are you a health oriented person? ______________________

What do you do on a regular basis to improve your health? ______________________

When was your last complete medical examination? (Physical) ______________

Family Physician ______________ Specialty ______________________

Additional Physician______________ Specialty ______________________

Do you have or have you had any of the following: (Please circle Y for Yes and N for No)

Y N Heart trouble	Y N Hepatitis A or B or C	Y N Pain in the Chest
Y N Joint Replacement	Y N HIV+	Y N Headaches
Y N High Blood Pressure	Y N Tumor or Cancer	Y N Easily Fatigued
Y N Kidney Disease	Y N Arthritis	Y N Shortness of Breath
Y N Liver Disease	Y N Asthma	Y N Persistent Cough
Y N Stroke	Y N Hay Fever	Y N Fainting or Dizziness
Y N Diabetes	Y N Sleep Apnea	Y N Latex allergy
Y N Tuberculosis	Y N Allergic to Medications	Y N Major Operation
Y N Anemia	Y N Ulcers	Y N Serious Accident
Y N Tobacco Dependency	Y N Prolonged Bleeding	
Y N Alcohol Dependency	Y N Nervous Disorder	Y N Pregnant Now
Y N Drug Dependency	Y N Psychiatric Treatment	Y N Menopause

If you marked yes to any of the above please explain in the space provided below

____

____

____

____

____

____

____

What medications are you now taking? Including non-prescription medications.

Medication	Dosage	How many	How Frequent	For what Condition

____

Signature of Patient or Guardian Date

Child Dental Questionnaire

Last First Middle Name you want to be called

The following questions will allow Dr. Maurstad to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential. These questions should be answered with your child in mind and with their help.

Age Grade School Sports/Interests

When was the date of your child's last dental visit?

Is your child having any discomfort at this time? [] Yes [] No

Does your child have or ever had any of the following:

MOUTH		**TEETH**	
Bleeding, sore gums	[] Yes [] No	Loose teeth	[] Yes [] No
Unpleasant taste/bad breath	[] Yes [] No	Sensitive to hot	[] Yes [] No
Burning tongue/lips	[] Yes [] No	Sensitive to cold	[] Yes [] No
Frequent blister, lips/mouth	[] Yes [] No	Sensitive to sweets	[] Yes [] No
Swelling/lumps in mouth	[] Yes [] No	Sensitive to biting	[] Yes [] No
Mouth Breather	[] Yes [] No	Food getting caught	[] Yes [] No
Biting cheeks/lips	[] Yes [] No	Clenching/grinding	[] Yes [] No
Clicking/popping jaw	[] Yes [] No	If so, when	
Difficulty opening/closing jaw	[] Yes [] No	Shifting in bite	[] Yes [] No
		Change in bite	[] Yes [] No

Does your child use the following?

Brush	[] Yes [] No	Dental Floss	[] Yes [] No
Fluoride rinse	[] Yes [] No	Other []	

How often does your child brush?________ Their brush is : [] Soft [] Medium [] Hard

What is the most important thing to you about your child's teeth:

Does your child fear dentistry? If so, what are they afraid of?

Is there anything else you would like to share about your child's dental concerns?

Has your child had any changes in their bite over the past several years?

Are you aware of a bite problem? If so, what is your understanding of the problem?

Has your child had any orthodontic treatment, consultation, or orthodontic guidance in the past?

If so, please describe when, and what took place.

Are you pleased with the result?

Does your child have, or ever had a thumb or finger sucking habit? If so, please tell us what and when.

Dental treatment, like all health care services, entails a combination of time, quality, and cost.

Please rank in order of importance with number one being most.

______time ______quality ______cost

In your opinion, is orthodontic care more for cosmetics, or for oral health?

Are you concerned your child's oral conditions may be serious? If so, please share your thoughts with us.

Parent/Guardian signature Date