

## Gregory F. Kubik, D.D.S., M.S.

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(815) 455-7757

## **Orthodontics, Oral Facial Orthopedics** for Adults and Children

Welcome to our office! Your first visit to our office will be for the purpose of a thorough examination and the Doctor's opinion as to whether treatment is indicated. If it appears that treatment is needed at this time, full diagnostic records may be requested by the Doctor. There is no fee for this initial evaluation by Dr. Kubik.

## Please fill in the following:

Patient's name		Birthdate_	
			Month/Day/Year
Home Address		Sex M 🗆	F□
No. Street			
City Zip	Home phone	والمستعجب ا	in the second
Previous address			
No. Street		City	State
Employed by	Occupation		A
Business address	Business phone	Sec. 1	
Spouse's name	Occupation	a la come	
Employed by	Business phone		
Business address		- 19 A.	
Person responsible for this account			
Social Security number of person responsible for this acco	ount		
Have you had previous orthodontic treatment?	If so, by whom	1	
Referred by	Family dentist	1.1	
	Address		a start and
Are you covered by insurance for orthodontic treatment?	Yes D No D		
If so, give name of company and policy no.			and the second

Date

Signature



Association of Orthodontists "

ADULT

Do you have a current medical problem? Yes       No       What         Have you ever had any of the following:       Shortness of breath         Lung trouble (TB, asthma, emphysema)       Swelling of ankles or feet         Hepatitis, liver disease, jaundice       Pain, pressure or tightness in chest         Arthritis, sore joints       Heart attack         Diabetes       Rheumatic fever         Excessive bleeding       High blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         VD (syphilis, gonornhea)       Headaches when lying down         X-ray, Indium, cobalt treatments       Using anticoagulents         On a prescribed diet       Using Dilantin         Using thormones (including birth control)       Stomach trouble (ulcer, other)         Are you now taking or using medicines for:       Diabetes (allis or shots)       Blood (liver, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)       Stomach trouble (ulcer, other)         Steping       Headaches       Arthritis or rheumatism       (digitalis, nitroglycerin, resorpin)         Attributics       Other drugs or medicines (please specify)       Attributics       Headaches         Antibiotics       Other drugs or medicines (please specify)       Aspirin       Heave you ever been isk from, shown an allergy to, o	Medical History Name of physician	City_			Phone		
Have you ever had any of the following:       Shortness of breath         I Lung trouble (TB, asthma, emphysema)       Swelling of ankles or feet         Hepatitis, liver disease, jaundice       Pain, pressure or tightness in chest         I Habetatis, liver disease, jaundice       Pain, pressure or tightness in chest         Diabetes       Reumatic faver         Excessive bleeding       High blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         VD (syphilis, gonorhea)       Headaches when lying down         Xray, indium, cobalt treatments       Headaches when lying down         Are you now:       Using anticoagulents         On a prescribed diet       Using other medicines (please specify)         Using thyroids       Using other medicines (please specify)         Using hormones (including birth control)       Are you now:         Are you now taking or using medicines for:       Blood (liver, iron pilis)         Ibabetes (pills or shots)       Blood (liver, iron pilis)         Ibabetes (pills or shots)       Blood (liver, iron pilis)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Steeping       Nathitis or meunatism         (digitalis, nitroglycerin, resorpin)       Altery         Have you ever been sick from, shown an allergy to, or told not to						and the second sec	
Nervous breakdown, psychotherapy       Shotness of breath         Lung trouble (IR, asthma, emphysema)       Swelling of ankles or feet         Hepatitis, lover disease, jaundice       Pain, pressure or tightness in chest         Arthritis, sore joints       Reumatic fever         Excessive bileding       Nigh blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         V0 (syphilis, gonorthea)       Headaches when lying down         Xray, Indium, cobalt treatments         Are you now:       Pregnant         On a prescribed diet       Using Dilantin         Using Thyroids       Using dother medicines (please specify)         Using hormones (including birth control)       Are you now taking or using medicines for:         Diabetes (pills or shots)       Blood (liver, iron pills)         Diabetes (cills or shots)       Blood flower, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Bleeping       Headaches         Heat to blood pressure       Arthritis or medicines (please specify)         Have you ever been sick from, shown an allergy to, or told not to take:       Novocaine (or other dental anesthetic)         Codeine       Other drugs or medicines (please specify)         Aspirin       Meret or         Have you ever be	Do you have a current medical problem? Yes	U No U	V	Vhat			-
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Hepatitis, liver disease, jaundice       Pain, pressure or tightness in chest         Arthritis, sore joints       Heart attack         Diabetes       Renumatic fever         Excessive bleeding       High blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         VD (syphilis, gonorthea)       Headaches when lying down         Xray, indium, cobalt treatments       Headaches when lying down         Are you now:       Pregnant         On a prescribed diet       Using Dilantin         Using Thyroids       Using other medicines (please specify)         Using thromones (including birth control)       Stomach trouble (ulcer, other)         Are you now taking or using medicines for:       Stomach trouble (ulcer, other)         Diabetes (pills or shots)       Blood (liver, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Sleeping       Headaches         Haet or blood pressure       Arthritis or rheumatism         (digitalis, nitroglycerin, resorpin)       Allergy         Have you ever been sick from, shown an allergy to, or told not to take:         Antibiotics       No         Ware you ever head a tumor or cancer? Yes       No         Have you ever head a major operation?       Yes <td< td=""><td>Nervous breakdown, psychotherapy</td><td></td><td></td><td>Shortness of breath</td><td></td><td></td><td></td></td<>	Nervous breakdown, psychotherapy			Shortness of breath			
Arthritis, sore joints       Heart attack         Diabetes       Rheumatic fever         Excessive bleeding       High blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         VD (syphilis, gonorrhea)       Headaches when lying down         Xray, indium, cobalt treatments       Are you now:         Pregnant       Using anticoagulents         On a prescribed diet       Using Dilantin         Using thormones (including birth control)       Variag medicines for:         Diabetes (pills or shots)       Blood (liver, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Steeping       Headaches         (digitalis, nitroglycerin, resorpin)       Altergy         Heave you ever been sick from, shown an allergy to, or told not to take:       Novocaine (or other dental anesthetic)         Codeline       Other drugs or medicines (please specify)         Have you ever had a tumor or cancer? Yes       No         Mave you ever had a tumor or cancer? Yes       No         Mave you ever had a major operation?       Yes         Have you ever had a major operation?       No         Mave you ever had a major operation?       No         Mave you ever had a major operation?       No         Have yo	Lung trouble (TB, asthma, emphysema)			Swelling of ankles or feet	Ε		
Diabetes       Pheumatic fever         Excessive bleeding       High blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         VD (syphilis, gonorrhea)       Headaches when lying down         Xray, indium, cobalt treatments         Are you now:       Pregnant         Pregnant       Using anticoagulents         On a prescribed diet       Using other medicines (please specify)         Using throrods       Using other medicines (please specify)         Using throrods       Stomach trouble (ulcer, other)         Are you now taking or using medicines for:       Blood (liver, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Sleeping       Headaches         Heart or blood pressure       Arthritis or rheumatism         (digitalis, nitroglycerin, resorpin)       Allergy         Have you ever head a tumor or cancer? Yes       No         Mave you ever had a major operation? Yes       No         Mave you ever had a major operation?       Yes         Have you ever had no more than 3 weeks?       Codeine         Mave you ever had no more than 3 weeks?       Codeine         If yes, where is the pain?       Codeine         Have you presently having dental pain?       Codeine <td>Hepatitis, liver disease, jaundice</td> <td></td> <td></td> <td>Pain, pressure or tightnes</td> <td>ss in chest</td> <td></td> <td></td>	Hepatitis, liver disease, jaundice			Pain, pressure or tightnes	ss in chest		
Excessive bleeding       High blood pressure         Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         VD (syphilis, gonorrhea)       Headaches when lying down         Xray, indium, cobalt treatments         Are you now:       Pregnant         On a prescribed diet       Using anticoagulents         Using Thyroids       Using other medicines (please specify)         VD log hormones (including birth control)	Arthritis, sore joints			Heart attack			
Blood trouble, anemia, leukemia       Fainting spells, convulsions, epilepsy         V0 (syphilis, gonorrhea)       Headaches when lying down         Xray, indium, cobalt treatments       Headaches when lying down         Are you now:       Using anticoagulents         On a prescribed diet       Using anticoagulents         Ising Thyroids       Using other medicines (please specify)         Using hormones (including birth control)	Diabetes			Rheumatic fever			
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□ Xray, Indium, cobalt treatments         Are you now:         □ Pregnant       □ Using anticoagulents         □ On a prescribed diet       □ Using other medicines (please specify)         □ Using Thyroids       □ Using other medicines (please specify)         □ Using thermones (including birth control)	Blood trouble, anemia, leukemia			Fainting spells, convulsion	ons, epilepsy		
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On a prescribed diet       Using Dilantin         Using Thyroids       Using other medicines (please specify)         Using hormones (including birth control)	Are you now:						
On a prescribed diet       Using Dilantin         Using Thyroids       Using other medicines (please specify)         Using hormones (including birth control)	Pregnant			Using anticoagulents			
Using hormones (including birth control)         Are you now taking or using medicines for:         Diabetes (pills or shots)       Blood (liver, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Sleeping       Headaches         Heart or blood pressure       Arthritis or rheumatism         (digitalis, nitroglycerin, resorpin)       Allergy         Have you ever been sick from, shown an allergy to, or told not to take:       Novocaine (or other dental anesthetic)         Codeine       Other drugs or medicines (please specify)         Aspirin	On a prescribed diet		_				
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Diabetes (pills or shots)       Blood (liver, iron pills)         Nerves (tranquilizers)       Stomach trouble (ulcer, other)         Sleeping       Headaches         Heart or blood pressure       Arthritis or rheumatism         (digitalis, nitroglycerin, resorpin)       Allergy         Have you ever been sick from, shown an allergy to, or told not to take:       Novocaine (or other dental anesthetic)         Codeine       Other drugs or medicines (please specify)         Aspirin		1.1.1.1				1.00	<u></u>
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Heart or blood pressure       Arthritis or rheumatism         (digitalis, nitroglycerin, resorpin)       Allergy         Have you ever been sick from, shown an allergy to, or told not to take:       Novocaine (or other dental anesthetic)         Codeine       Other drugs or medicines (please specify)         Aspirin					(ner)		
(digitalis, nitroglycerin, resorpin)       □ Allergy         Have you ever been sick from, shown an allergy to, or told not to take:       □ Antibiotics       □ Novocaine (or other dental anesthetic)         □ Codeine       □ Other drugs or medicines (please specify)       □ Aspirin         □ Have you ever had a tumor or cancer? Yes       No       Where?         □ Have you ever had a major operation? Yes       No       Where?         □ Have you ever been involved in a serious accident? Yes       No       Describe:         □ Date of last medical exam							
Have you ever been sick from, shown an allergy to, or told not to take:  Antibiotics  Other drugs or medicines (please specify)  Aspirin  Ave you ever had a tumor or cancer? Yes No Vhere?  Ave you ever had a major operation? Yes No Vhere?  Ave you ever been involved in a serious accident? Yes No Vhere?  No Vhere?  Ave you ever been involved in a serious accident? Yes No Vhere?  Ave you come to this office for relief of pain?  Kave you come to this office for relief of pain?  Ave you had the pain more than 3 weeks?  Are you presently having dental pain?  If you have any type of dental insurance, please complete Name of insurance company  Name of dental plan  Employee  Patient  Relationship to employee  Employee  Patient's birthdate  Employer's Address					11 U.S. Ser		
Have you ever had a major operation? Yes No What kind? Have you ever been involved in a serious accident? Yes No Describe: Date of last medical exam							
Have you ever been involved in a serious accident? Yes No Describe:	Have you ever had a tumor or cancer? Yes $\Box$	No 🗆	Whe				
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Have you had the pain more than 3 weeks?   Are you presently having dental pain?   Insurance Information If you have any type of dental insurance, please complete Name of insurance company Group number Mame of dental plan Group number Employee Employee social security no Patient Relationship to employee Patient's birthdate Employer							
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				1976 - A		1.1	1
Union local no Address	Stre	et		City	Area code	Phone	1.

## **Dental History**

		Yes	No
Have you had orthodontic treatment? If Yes, when			
Do you have unreplaced missing teeth?			
If Yes, why haven't you had them replaced?			
Was it ever suggested?			
Do you have difficulty swallowing?			
Do your gums bleed when brushing your teeth?			
Have you ever had professional instructions on dental home	e care?		
Is any part of your mouth sensitive to temperature, or press If Yes, which part?	ure?		
Do you have any pain or soreness around the eyes or ears?			
Are you dissatisfied with your teeth and their appearance?			
Have you ever had a thumb or finger sucking habit?			
If Yes, has it been discontinued and when?			
Do you breathe predominently through your mouth?			
If Yes, why do you feel this occurs?	and the second	<u></u>	
Have you had a history of frequent ear, nose or throat infec	tions?		
Have you had tonsils and/or adenoids removed?			
Occlusal Screening			
Do you clench or grind your teeth during the day?			
Have you been made aware of clenching or grinding your te	eth during the night?		
Do you have chronic headaches, or neck and shoulder pains	\$?		
Do you ever wake up with an awareness of, or about, your to or jaw like you've had them clenched in your sleep?	eeth		
Do you have any awareness in the muscles of your neck or	shoulders?		
Do you have a tight or stiff neck?			
Do you now, or have you ever had, pain in your jaw joint or of your face (in and about the ears)?	the sides		
Do you have a clicking jaw joint or have you ever experience inability to move your jaw or open your mouth widely?	ed an		
Which side do you chew on? R  L Both			
Do you notice any of the following:			
Ringing in the ears			
Neck Pains			
Back Pains			
Headaches			
Popping, clicking or grating sound in the jaw			
Have you ever been in an accident?			
Has there ever been a blow to the jaw?		When	

	Yes	NO
Is there a specific orthodontic problem that concerns you?		
If Yes, please describe:		