

David C.

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Orthodontist



Member American Association of Orthodontists



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Patient Information

Patient's Name M F Birthdate Age
Nickname Telephone
Address How long at this address
Father's Name Business telephone
Father's Occupation Employer No. of years employed
Mother's Name Business telephone
Mother's Occupation Employer No. of years employed
Special Family Situation (different legal guardian, responsible party, does not live with mom or dad, divorced, etc.)

School Grade What musical instruments are played?
Family Dentist Who referred you to our practice?
Family Physician Address/Phone #

Brothers or Sisters:

Name M F Birthdate Age
Name M F Birthdate Age
Name M F Birthdate Age
Name M F Birthdate Age

Medical/Dental History Summary

Previous major medical/dental problems
Present major medical/dental problems
Medications currently taking
Have any other family members had Orthodontic Treatment? (if yes, by whom and when)

Has the patient had prior orthodontic treatment or been seen by an orthodontist?
History of Trauma/accidents to face or teeth
Why are you seeking treatment?

Environmental and Functional Considerations

Have Tonsils or Adenoids been removed? Yes No
Was excessive finger or thumb sucking ever a problem? Yes No
Does the Patient:
Grind teeth? Yes No
Take speech therapy? Yes No At a younger age
Have Asthma? Yes No
Have allergies to... Drugs Seasonal Grasses Food Other
Take allergy treatments? Yes No
Have frequent? Colds Stuffy Nose Sore Throats Tonsillitis
Ear Infections/History of ear tubes Sinus Infections
Have difficulties breathing through the nose? Never Sometimes Usually
Snore at night? Never Sometimes Usually

Insurance information

Is the patient covered under any dental insurance plan which has orthodontic benefits? Yes No
If yes, list insurance information:
Type of insurance
Social Security # Group #

# Health History

## I. Circle Appropriate Answer:

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?  
Why? \_\_\_\_\_
4. Yes No Are you being treated by a health care provider now?  
For what? \_\_\_\_\_
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

## II. Have you experienced:

- |            |  |            |                        |
|------------|--|------------|------------------------|
| 7. Yes No  | Chest pain (angina)?                     | 18. Yes No | Dizziness?             |
| 8. Yes No  | Swollen ankles?                          | 19. Yes No | Ringing in ears?       |
| 9. Yes No  | Shortness of breath?                     | 20. Yes No | Headaches?             |
| 10. Yes No | Recent weight loss, fever, night sweats? | 21. Yes No | Fainting spells?       |
| 11. Yes No | Persistent cough, coughing up blood?     | 22. Yes No | Blurred vision?        |
| 12. Yes No | Bleeding problems, bruising easily?      | 23. Yes No | Seizures?              |
| 13. Yes No | Sinus problems?                          | 24. Yes No | Excessive thirst?      |
| 14. Yes No | Difficulty swallowing?                   | 25. Yes No | Frequent urination?    |
| 15. Yes No | Diarrhea, constipation, blood in stools? | 26. Yes No | Dry mouth?             |
| 16. Yes No | Frequent vomiting, nausea?               | 27. Yes No | Jaundice or yellowing? |
| 17. Yes No | Difficulty urinating, blood in urine?    | 28. Yes No | Joint pain, stiffness? |

## III. Do you have or have you had:

- |            |   |            |                           |
|------------|---|------------|---------------------------|
| 29. Yes No | Heart Disease?                              | 40. Yes No | AIDS or ARC?              |
| 30. Yes No | Heart attack, heart defects?                | 41. Yes No | Tumors, cancer?           |
| 31. Yes No | Heart murmurs?                              | 42. Yes No | Arthritis, rheumatism?    |
| 32. Yes No | Rheumatic fever?                            | 43. Yes No | Eye disease?              |
| 33. Yes No | Stroke, hardening of the arteries?          | 44. Yes No | Skin disease?             |
| 34. Yes No | High blood pressure?                        | 45. Yes No | Anemia, blood problems?   |
| 35. Yes No | TB, emphysema, other lung disease?          | 46. Yes No | VD (syphilis, gonorrhea)? |
| 36. Yes No | Hepatitis, other liver disease?             | 47. Yes No | Herpes?                   |
| 37. Yes No | Stomach problems, ulcers?                   | 48. Yes No | Kidney, bladder disease?  |
| 38. Yes No | ALLERGIES: to drugs, foods, medications?    | 49. Yes No | Thyroid, adrenal disease? |
| 39. Yes No | Family history of diabetes, heart problems? | 50. Yes No | Diabetes?                 |

## IV. Do you have or have you had:

- |            |                         |            |                     |
|------------|-------------------------|------------|---------------------|
| 51. Yes No | Psychiatric care?       | 56. Yes No | Hospitalization?    |
| 52. Yes No | Radiation treatments?   | 57. Yes No | Blood transfusions? |
| 53. Yes No | Chemotherapy?           | 58. Yes No | Surgeries?          |
| 54. Yes No | Prosthetic heart valve? | 59. Yes No | Pacemaker?          |
| 55. Yes No | Artificial joint?       | 60. Yes No | Contact lenses?     |

## V. Are you taking:

- |            |  |            |                                  |
|------------|--|------------|----------------------------------|
| 61. Yes No | Recreational drugs?  | 63. Yes No | Tobacco or Nicotine in any form? |
| 62. Yes No | Drugs, medications, (incl. Aspirin)?<br>Please list: _____ | 64. Yes No | Alcohol?                         |

## VI. Women only

- |            |  |            |                             |
|------------|--|------------|-----------------------------|
| 65. Yes No | Are you or could you be pregnant or nursing? | 66. Yes No | Taking birth control pills? |
|------------|--|------------|-----------------------------|

## VII. All patients

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?  
If so, please explain: \_\_\_\_\_

In case of emergency please contact (Relative not living with you): Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

To the best of my knowledge, I have answered every question completely and accurately. I will inform the office of any change in my health and/or medication. I understand that where appropriate, credit bureau reports may be obtained.

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_