

David C.

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Practice limited to orthodontics and dentofacial orthopedics

Member American Association of Orthodontists



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Adult Patient Information

Form fields for Patient's Name, Nickname, Address, Business Address, Spouse's Name, Family Dentist, Family Physician, Birthdate, Occupation, How long at this address?, Telephone, Business Telephone, No. of years employed, Who referred you to our practice?, Address/Phone #.

Children: Name, Birthdate, Age fields for up to four children.

Medical/Dental History Summary

Form fields for Medical/Dental History Summary including: Are you presently under the care of any other health care professional?, Previous major medical/dental problems, Present major medical/dental problems, Medications currently taking, Have any other family members had Orthodontic Treatment?, Have you had prior orthodontic treatment or been seen by an orthodontist?, History of Trauma/accidents to face or teeth, Have you ever had any periodontal treatment?, Why are you seeking treatment?

Environmental and Functional Considerations

Form fields for Environmental and Functional Considerations including: Have Tonsils or Adenoids been removed?, Was excessive finger or thumb sucking ever a problem?, Do your gums bleed when you floss or brush your teeth?, Do your jaw-joints crack, pop or make sounds?, Does your jaw ever get stuck open or closed?, Do you have pain in your jaw-joint, cheeks or ears?, Do you have frequent headaches?, Do you grind your teeth or clench your jaws?

Insurance information

Form fields for Insurance information including: Are you covered under any dental insurance plan which has orthodontic benefits?, 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)?
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: _____

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.

Patient's Signature _____ Date _____