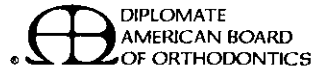


David C.

Spokane D.M.D., M.S.



Practice limited to orthodontics and dentofacial orthopedics



Member American Association of Orthodontists



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Patient Information

Patient's Name, Nickname, Address, Father's Name, Mother's Name, Special Family Situation, Birthdate, Telephone, How long at this address, Business telephone, No. of years employed

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

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?, Was excessive finger or thumb sucking ever a problem?, Does the Patient: Grind teeth?, Take speech therapy?, Have Asthma?, Have allergies to..., Take allergy treatments?, Have frequent?, Have difficulties breathing through the nose?, Snore at night?

Insurance information

Is the patient 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: _____

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 _____