David C.
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Orthodontics

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KARSKI & SPOKANE ORTHODONTICS

659 Castle Creek Dr. • Seven Fields, PA • 724-591-5758

Adult Patient Information

Patient's Name _____ ❑ M ❑ F Birthdate _____ Age _____
Nickname _____ Occupation _____
Address _____ How long at this address? _____ ❑ Rent ❑ Own
Email _____ Telephone _____
Business Address _____ Business Telephone _____ No. of years employed _____

Spouse's Name _____ Occupation _____ Birthdate _____
Business Address _____ Business Telephone _____ No. of years employed _____
Family Dentist _____ Who referred you to our practice? _____

Family Physician _____ Address/Phone # _____

Children:
Name _____ ❑ M ❑ F Birthdate _____ Age _____
Name _____ ❑ M ❑ F Birthdate _____ Age _____
Name _____ ❑ M ❑ F Birthdate _____ Age _____
Name _____ ❑ M ❑ F Birthdate _____ Age _____

Medical/Dental History Summary

Are you presently under the care of any other health care professional? ❑ No ❑ Yes _____
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) _____

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? (gum surgery, grafts, deep cleaning under the gums, etc.) ❑ No ❑ Yes

Why are you seeking treatment? _____

Environmental and Functional Considerations

Have tonsils or adenoids been removed?	❑ No	❑ Yes	
Was excessive finger or thumb sucking ever a problem?	❑ No	❑ Yes	
Do your gums bleed when you floss or brush your teeth?	❑ Never	❑ Sometimes	❑ Usually
Do your jaw joints crack, pop or make sounds?	❑ Never	❑ Sometimes	❑ Usually
Does your jaw ever get stuck open or closed?	❑ Never	❑ Sometimes	❑ Usually
Do you have pain in your jaw joint, cheeks or ears?	❑ Never	❑ Sometimes	❑ Usually
Do you have frequent headaches?	❑ Never	❑ Sometimes	❑ Usually
Do you grind your teeth or clench your jaws?	❑ Never	❑ Sometimes	❑ Usually

Insurance information

Are you 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

Patients's name: _____

Height _____ Weight _____

ASA Status _____ *(Office Use Only)*

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/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.

Patient/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____ *Rev 2-18*