

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 _____

I. Circle Appropriate Answer:

ASA Status _____

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?

(Office Use Only)

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 _____



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PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient or Parent's Signature (if minor)

Print Patient's Name

Date



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Consent to Use by David C. Spokane DMD, MS
and Melissa R. Karski DMD, MDS

of Photograph, Likeness, Picture, Name, Comments, Testimonial, Or Voice

I, _____(name), do hereby fully and freely consent to the use, by David C. Spokane DMD, MS, Melissa R. Karski DMD, MDS and /or its agents and assigns, of my photograph, picture, name, comments, testimonial, and/or promotion or advocacy of Dr. Spokane, Dr. Karski and Karski-Spokane Orthodontics.

I do hereby release and hold harmless Dr. David C. Spokane, Dr. Melissa R. Karski and/or its agents and assigns from any liability with regard to the above stated purposes arising out of said consent or use. I hereby grant Dr. Spokane, Dr. Karski and/or its agents and assigns the right to use, my photograph, or likeness, picture, name, comments, testimonial, and/or voice to advertise and publicize the interests of Dr. Spokane and Dr. Karski.

Patient or Parent's Signature (if minor)

Print Patient's Name

Date