

David C.

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

Orthodontics

Chippewa • New Castle • Center Twp • Ellwood City • 724-846-9666

KARSKI &
SPOKANE
ORTHODONTICS

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

Patient Information

Patient's Name _____ ☐ M ☐ F Birthdate _____ Age _____
Height _____ Weight _____ Telephone _____ Email _____
+/- Address _____ +/-How long at this address _____ ☐ Rent ☐ Own +/-
Father's Name _____ Birthdate _____ Business Telephone _____
+/- Father's Occupation _____ Employer _____ No. of years employed _____ +/-
+/- Mother's Name _____ Birthdate _____ 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

Patients's name: _____

Height _____

Weight _____

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?

ASA Status _____

(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