Patient Information

All About You

Name: _____
First Last MI Mr Mrs Ms Dr

I prefer to be called: _____

Male:___ Female:___ Birthdate:___/___/___ Age: ___
Single Married Divorced Widowed Separated

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____

Cell #: ( ) _____

Email: _____

Work #: ( ) _____ Ext: _____

Whom may we thank for referring you?: _____

Emergency Contact Information

His/Her Name: _____

Relation: _____

Phone: ( ) _____ Ext: _____

Dental History

General dentist: _____

Date of last exam: _____

What are the main concerns that you would like orthodontics to accomplish?: _____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: mouth/teeth/chin?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No
If yes: While awake? While asleep?

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/ TMD)? ☐ Yes ☐ No

Spoonhower Orthodontics
4444 Davidson Road,
Hilliard, Ohio 43026
T 330.800.5965
www.spoonorthohilliard.com

Medical History

Your current medical condition is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?
☐ Yes ☐ No Please explain: _____

Physician's name: _____

Are you taking any prescription/over-the-counter drugs?
☐ Yes ☐ No Please list each one: _____

_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal bleeding
Y N Anemia/radiation treatment
Y N Artificial bones/joints/valves
Y N Asthma
Y N Arthritis
Y N Blood transfusion
Y N Cancer/chemotherapy
Y N Diabetes
Y N Congenital heart defects
Y N Tuberculosis
Y N Difficulty breathing
Y N Glaucoma
Y N Drug or alcohol abuse
Y N Emphysema
Y N Epilepsy/seizures/fainting
Y N Fever blisters/herpes
Y N Heart murmur
Y N Heart surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/low blood pressure
Y N HIV positive/AIDS
Y N Hospitalization
Y N Kidney problems
Y N Mitral valve prolapse
Y N Psychiatric problems
Y N Rheumatic/Scarlet Fever
Y N Shingles
Y N Sinus Problems
Y N Severe/Frequent Headaches
Y N Heart Attack
Y N Ulcers/Colitis
Y N Venereal Diseases

Are you pregnant? ☐ Yes ☐ No

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Metals/Plastics	Y N Other

Please list any other drugs/materials that you are allergic to:

_____

_____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

_____
Signature Date

_____
Reviewed

Account & Insurance Information

Patient Name: _____ Date: _____

Birthdate: _____

Responsible Party

Name: _____

Relation: _____ SS#: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____ Email: _____

Employer: _____ Work #: ( ) _____

Primary Dental Insurance

Policy Holder: _____

Relation: _____

Address: _____

City: _____

State: _____

Zip: _____

Home #: ( ) _____

SS#: _____

Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( ) _____ Ext: _____

Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

ID #: _____

Phone #: _____

Secondary Dental Insurance

Policy Holder: _____

Relation: _____

Address: _____

City: _____

State: _____

Zip: _____

Home #: ( ) _____

SS#: _____

Birthdate: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: ( ) _____ Ext: _____

Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Group #: _____

Plan #: _____

ID #: _____

Phone #: _____