DARIN R. LUNT DDS, MS

PRIDE IN EVERY SMILE
72 Remick Blvd
Springboro, OH 45066
937-886-2700

8769 N Main St
Dayton, OH 45415
937-890-9600

APPOINTMENT DATE _____

PATIENT INFORMATION

NAME _____ I PREFER TO BE CALLED _____

AGE _____ BIRTH DATE _____ ☐ MALE ☐ FEMALE SOCIAL SECURITY # _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ PARTNERED ☐ SEPERATED

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

GENERAL DENTIST _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU _____

OTHER FAMILY MEMBERS SEEN BY US _____

SPOUSE

NAME _____ BIRTH DATE _____ SOCIAL SECURITY # _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

PRIMARY INSURANCE INFORMATION

INSURED'S NAME _____ BIRTH DATE _____ SOCIAL SECURITY # _____

INSURANCE COMPANY _____ PHONE NUMBER _____

SECONDARY INSURANCE INFORMATION (if applicable)

INSURED'S NAME _____ BIRTH DATE _____ SOCIAL SECURITY # _____

INSURANCE COMPANY _____ PHONE NUMBER _____

Lunt Orthodontics reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If insurance is accepted, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits, and I assign directly to Lunt Orthodontics all insurance benefits otherwise payable to me. I further authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

SIGNATURE _____ **DATE** _____

DENTAL/MEDICAL HISTORY

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

_____

_____

HAVE YOU EVER BEEN EVALUATED FOR OR HAD ORTHODONTIC CARE BEFORE? □ YES □ NO

HAVE YOU HAD ANY INJURIES TO THE FACE, MOUTH, TEETH OR CHIN? □ YES □ NO

HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK? □ YES □ NO

DO YOU HAVE PAIN/TENDERNESS IN THE JAW JOINT (TMJ/TMD)? □ YES □ NO

DO YOU HAVE ANY MISSING OR EXTRA PERMANENT TEETH? □ YES □ NO

DO YOU STILL HAVE WISDOM TEETH? □ YES □ NO

YOUR CURRENT DENTAL HEALTH □ GOOD □ FAIR □ POOR

DO YOU HAVE ANY SPEECH PROBLEMS? □ YES □ NO

DO YOU GENERALLY BREATHE THROUGH YOUR MOUTH? □ YES □ NO

IF YES,

WHILE AWAKE □ YES □ NO

WHILE ASLEEP □ YES □ NO

DO YOU HAVE A PERSONAL PHYSICIAN □ YES □ NO

PHYSICIAN'S NAME _____

PHONE _____ DATE OF LAST VISIT _____

YOUR CURRENT PHYSICAL HEALTH □ GOOD □ FAIR □ POOR

ARE YOU CURRENTLY BEING TREATED FOR AN AILMENT? □ YES □ NO

IF YES, please explain _____

_____

_____

HAVE YOU HAD ANY METAL RODS, PINS OR IMPLANTS? □ YES □ NO

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL PILLS? □ YES □ NO

ARE YOU PREGNANT? □ YES □ NO

ARE YOU NURSING? □ YES □ NO

LIST ALL DRUGS THAT YOU ARE CURRENTLY TAKING (PRESCRIPTION AND OVER-THE-COUNTER):

_____

_____

_____

LIST ALL DRUGS/THINGS YOU ARE ALLERGIC TO:

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS?

□ ABNORMAL BLEEDING	□ CONVULSION	□ HIGH BLOOD PRESSURE	□ RADIATION TREATMENT	□ TUBERCULOSIS
□ AIDS	□ DIABETES	□ HIV+	□ RHEUMATIC FEVER	□ VENEREAL DISEASE
□ ALCOHOL/DRUG ABUSE	□ EPILEPSY	□ KIDNEY PROBLEMS	□ SCARLET FEVER	□ ANY OTHER MEDICAL CONDITIONS NOT LISTED ON THIS FORM (please list)
□ ANEMIA	□ EYE PROBLEMS	□ LEUKEMIA	□ SEIZURES	
□ ASTHMA	□ FAINTING	□ LIVER DISEASE	□ SHINGLES	
□ ARTHRITIS	□ GLAUCOMA	□ LOW BLOOD PRESSURE	□ SICKLE CELL ANEMIA	
□ BLOOD TRANSFUSION	□ HEART DEFECT	□ LUPUS	□ SINUS PROBLEMS	
□ CANCER	□ HEART ATTACK	□ MITRAL VALVE PROLAPSE	□ STROKE	
□ COLITIS	□ HEPATITIS--TYPE_____	□ PACEMAKER	□ THYROID	
□ CHRONIC SINUS	□ HERPES	□ PSYCHIATRIC DISORDER	□ TOBACCO USE	

ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? □ **YES** □ **NO**

IF NOT, WHAT WOULD YOU CHANGE?_____

_____

OUR OFFICE IS HIPPA COMPLIANT AND COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND THAT IT IS MY RESPONSIBILITY TO INFORM LUNT ORTHODONTICS OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE DENTAL/ORTHODONTIC SERVICES THAT I NEED.

SIGNATURE _____ DATE_____

I HAVE VERBALLY REVIEWED THE DENTAL/MEDICAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

SIGNATURE _____ DATE_____

COMMENTS _____