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 ______________________________ NICKAME ______________________________

AGE ________ BIRTH DATE __________ ☐ MALE ☐ FEMALE HOBBIES ______________________________

ADDRESS ____

HOME PHONE ________________ CELL PHONE ________________ EMAIL ________________

GENERAL DENTIST ______________________________ PHONE ______________________________

WHOM MAY WE THANK FOR REFERRING YOU ______________________________________

OTHER FAMILY MEMBERS SEEN BY US ______________________________________

PARENT/INSURANCE INFORMATION

☐ FATHER ☐ STEP-FATHER ☐ GUARDIAN

NAME ______________________ BIRTH DATE ____________ SOCIAL SECURITY # ______________

HOME PHONE ________________ CELL PHONE ________________ EMAIL ________________

EMPLOYER ________________ OCCUPATION ________________ WORK PHONE ________________

INSURANCE COMPANY ______________________________ PHONE NUMBER ________________

☐ MOTHER ☐ STEP-MOTHER ☐ GUARDIAN

NAME ______________________ BIRTH DATE ____________ SOCIAL SECURITY # ______________

HOME PHONE ________________ CELL PHONE ________________ EMAIL ________________

EMPLOYER ________________ OCCUPATION ________________ WORK PHONE ________________

INSURANCE COMPANY ______________________________ PHONE NUMBER ________________

WHO IS RESPONSIBLE FOR THIS ACCOUNT ______________________________________

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?
____
____

HAS YOUR CHILD EVER BEEN EVALUATED FOR OR HAD ORTHODONTIC CARE BEFORE? ◻ YES ◻ NO

HAVE THERE BEEEN ANY INJURIES TO THE FACE, MOUTH, TEETH OR CHIN? ◻ YES ◻ NO

DOES YOUR CHILD REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ◻ 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

HAVE TONSILS OR ADENOIDS BEEN REMOVED? ◻ YES ◻ NO

YOUR CURRENT DENTAL HEALTH ◻ GOOD ◻ FAIR ◻ POOR

DOES YOUR CHILD BRUSH THEIR TEETH DAILY? ◻ YES ◻ NO

DOES YOUR CHILD FLOSS THEIR TEETH DAILY? ◻ YES ◻ NO

CHILD'S PHYSICIAN _______________________

PHONE ____________ DATE OF LAST VISIT ____________

YOUR CHILD'S CURRENT PHYSICAL HEALTH ◻ GOOD ◻ FAIR ◻ POOR

IS YOUR CHILD CURRENTLY BEING TREATED FOR AN AILMENT OR CONDITION? ◻ YES ◻ NO

IF YES, please explain _______________________
____
____

HAS PUBERTY BEGUN? ◻ YES ◻ NO

HAS MENSTRUATION BEGUN? ◻ YES ◻ NO

LIST ALL DRUGS THAT YOUR CHILD IS CURRENTLY TAKING (PRESCRIPTION AND OVER-THE-COUNTER):
____
____
____

LIST ALL DRUGS/THINGS YOUR CHILD IS ALLERGIC TO:
____
____

HAS YOUR CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS?

◻ ADD/ADHD	◻ CONVULSIONS	◻ HYPERACTIVITY	◻ PREGNANT/NURSING	◻ TUBERCULOSIS
◻ AIDS	◻ DIABETES	◻ JAW PROBLEMS	◻ PSYCHIATRIC DISORDER	◻ VENEREAL DISEASE
◻ ANEMIA	◻ EPILEPSY	◻ KIDNEY PROBLEMS	◻ RHEUMATIC FEVER	◻ ANY OTHER MEDICAL CONDITIONS NOT LISTED ON THIS FORM (please list)
◻ ASTHMA	◻ EYE PROBLEMS	◻ LEUKEMIA	◻ SCARLET FEVER	
◻ AUTISM	◻ FAINTING	◻ LIVER DISEASE	◻ SEIZURES	
◻ BLADDER	◻ HEARING	◻ HEARING PROBLEMS	◻ SICKLE CELL ANEMIA	____________
◻ CANCER	◻ HEART PROBLEMS	◻ LUPUS	◻ SORE THROATS (frequent)	____________
◻ CEREBRAL PALSY	◻ HEPATITIS--TYPE_____	◻ MENTAL RETARDATION	◻ SPEECH PROBLEMS	____________
◻ CHRONIC SINUS	◻ HEMOPHILIA	◻ MONONUCLEOSIS	◻ TETANUS	____________
◻ COLITIS	◻ HIV+	◻ MUMPS	◻ THYROID	____________

DOES/DID YOUR CHILD EXPERIENCE ANY OF THE FOLLOWING?

◻ BREAST FED ◻ GRINDING/CLENCHING TEETH ◻ LIP SUCKING/BITING ◻ MOUTH BREATHING ◻ NAIL BITING
◻ SPEECH PROBLEMS ◻ THUMB/FINGER SUCKING ◻ TONGUE THRUST ◻ USED PACIFICER

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING RECENT INJURIES, PENDING SURGERY, OR ANY OTHER PERTINENT INFORMATION WE SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED: _______________________
____

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 MY CHILD MAY NEED.

SIGNATURE _______________________ DATE____________

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

SIGNATURE _______________________ DATE____________

COMMENTS _______________________________________