



Creating Beautiful Healthy Smiles For Life!

Please complete this information form to help us become better acquainted and to be able to offer you the best possible care.

PATIENT INFORMATION

DATE _____ AGE _____ NAME OF SCHOOL (child) _____
PATIENT'S NAME _____ BIRTHDAY ___/___/___ [] MALE [] FEMALE
Last First MI D M Y
ADDRESS _____ CITY _____ PROV _____ PC _____
HOME PHONE _____ DENTIST'S NAME _____
CELL PHONE _____ OCCUPATION _____
WORK PHONE _____ Whom may we thank for referring you?
E-MAIL _____ [] Dentist [] Friend [] Family [] Website [] Other
FAMILY MEMBERS SEEN BY US _____

PARENT INFORMATION (please complete if patient is under the age of 18)

PATIENT LIVES WITH: [] MOTHER [] FATHER [] BOTH PARENTS [] OTHER (please specify) _____
PERSON RESPONSIBLE FOR THE ACCOUNT _____ RELATION _____
ADDRESS (if different from the patient) _____
CITY _____ PROV _____ PC _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

MOTHER'S INFORMATION
NAME _____
ADDRESS _____
(if different from patient)
OCCUPATION _____
HOME PHONE _____
WORK PHONE _____
CELL PHONE _____
E-MAIL _____

FATHER'S INFORMATION
NAME _____
ADDRESS _____
(if different from patient)
OCCUPATION _____
HOME PHONE _____
WORK PHONE _____
CELL PHONE _____
E-MAIL _____

INSURANCE

Our office charges the patient/parent/guardian directly for all professional services rendered. We will assist you in completing the necessary claim forms, so that you can receive the reimbursement to which you are entitled under your policy.
DO YOU HAVE ORTHODONTIC COVERAGE? [] YES [] NO [] UNSURE
NAME OF INSURANCE COMPANY: _____
POLICY #: _____ ID # _____
SUBSCRIBER'S NAME _____
SUBSCRIBER'S BIRTHDAY _____
DO YOU RECEIVE FUNDING THROUGH:
[] Indian Affairs [] Social Assistance [] A.I.S.H. [] Ward of Government [] Cleft Palate Clinic

DENTAL HISTORY

Reason for consultation (chief concern) _____

Is the patient happy with his/her smile? Yes No

If not, what would he/she change? _____

Has the patient ever had or been evaluated for orthodontic treatment? Yes No If yes, when? _____

Does the patient want treatment? Yes No

Has the patient ever experienced problems with their jaws (TMJ) Yes No

If yes, please specify _____

Have there been any injuries to the face, mouth, teeth, chin? Yes No

If yes, please explain _____

Has the patient had or presently have any of the following habits:

Thumb/ finger sucking Lip Biting Snoring Grinding Clenching Chronic Mouth Breathing

Speech Problems Tongue Thrusting Chewing/Eating Problems Sinus Problems Nail Biting

Does the patient see dentist regularly? Yes No

How often does patient brush? _____ How often does patient floss? _____

MEDICAL HISTORY

Physician's Name _____ Physician's Phone No. _____

Patient's current health is Good Fair Is the patient currently under care of a Physician? Yes No

If yes, please explain _____

Does the patient require antibiotics before dental treatment? Yes No If yes, please explain _____

Is the patient taking any prescription/over the counter drugs? Yes No

If yes, please list all _____

Does the patient have any allergies? Yes No

If yes, please list all _____

Do you use tobacco (smoking or chewing)? Yes No

For females: Has the patient started her menstrual cycle? Yes No Unsure

For females: Is the patient pregnant? Yes No Unsure

DOES THE PATIENT HAVE NOW, OR EVER HAD ANY OF THE FOLLOWING? (please check any that apply)

	YES		YES		YES
Anemia/Blood transfusion	<input type="checkbox"/>	Congenital heart defect	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	Pacemaker/Heart Attack/Stroke	<input type="checkbox"/>	Hospitalized for any reason	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Emotional/Psychiatric Problems	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Epilepsy/Seizures/Fainting	<input type="checkbox"/>	Shingles	<input type="checkbox"/>
Cancer/Chemotherapy	<input type="checkbox"/>	Fetal Alcohol Syndrome	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Colitis/Crohns	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>
Hepatitis (type _____)	<input type="checkbox"/>	Herpes (cold sores)	<input type="checkbox"/>		

If yes to any above, please explain _____

Describe any other medical conditions not listed _____

SIGNATURE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE PATIENT/PARENT/GUARDIAN **DATE**