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

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**