Patient Information

First Name ______ Preferred (First) ______ Last Name ______

Date of Birth ______ Age ______ Gender: ▢ Male ▢ Female

Patient's Chief Concern: ______

How did you hear about us? ▢ Friend/Family Member ▢ Internet ▢ Other advertisement: ______

Who Referred You ______ General Dentist ______ Last Checkup Date (if known) ______

Previous Orthodontic Consult? ▢ Yes ▢ No ______ Previous Orthodontist Name ______ Consult Date

Patient Address ______ City ______ Province ______

Patient Address Line 2 ______ Postal Code ______

Primary Phone ______ Other Phone ______ Email Address ______

If Patient is a child, person bringing Patient to their appointment: ______

Responsible Party Information 1 (Parent Or Self)

Relationship to Patient (Eg. Mother) ______ First Name ______ Last Name ______

If not same address as patient above:

Address ______ City ______ Province ______

Address Line 2 ______ Postal Code ______

Primary Phone ______ Other Phone ______ Email Address ______

Responsible Party Information 2

Relationship to Patient (Eg. Mother) ______ First Name ______ Last Name ______

If not same address as patient above:

Address ______ City ______ Province ______

Address Line 2 ______ Postal Code ______

Primary Phone ______ Other Phone ______ Email Address ______

Insurance Information (or we can take a photo copy of your card)

Dental Insurance available for orthodontics? ▢ Yes ▢ No May we check for you? ▢ Yes ▢ No

Are Insurance Subscriber and Responsible Party the same person? ▢ Yes ▢ No

Primary Subscriber's Name ______ Relationship to Patient ______ Date of Birth of Subscriber ______

Insurance Company ______ Group Number ______ Policy Number ______

Employer ______ Occupation ______

Insurance Information 2

Dental Insurance available for orthodontics? ▢ Yes ▢ No May we check for you? ▢ Yes ▢ No

Are Insurance Subscriber and Responsible Party the same person? ▢ Yes ▢ No

Primary Subscriber's Name	Relationship to Patient	Date of Birth of Subscriber
Insurance Company	Group Number	Policy Number
Employer	Occupation	

Medical History

Allergies ▢Yes ▢No ______

Medications ▢Yes ▢No ______

Disability ▢Yes ▢No ______

Illness or Surgeries ▢Yes ▢No ______

Abnormal Bleeding	▢Y ▢N	GI Disorders	▢Y ▢N	Nervous Disorders	▢Y ▢N
Anemia	▢Y ▢N	Heart Problems	▢Y ▢N	Pneumonia	▢Y ▢N
Arthritis	▢Y ▢N	Heart Murmur	▢Y ▢N	Chemotherapy	▢Y ▢N
Asthma or Hayfever	▢Y ▢N	Hepatitis	▢Y ▢N	Rheumatic Fever	▢Y ▢N
Bone Disorders	▢Y ▢N	Herpes	▢Y ▢N	Tuberculosis	▢Y ▢N
Cong. Heart Defect	▢Y ▢N	Hypertension	▢Y ▢N	Cancer	▢Y ▢N
Diabetes	▢Y ▢N	HIV/Aids	▢Y ▢N		
Epilepsy	▢Y ▢N	Kidney Problems	▢Y ▢N		

Dental History

Apprehensive about dental care	▢Y ▢N	Discomfort from teeth or gums	▢Y ▢N	Brush daily	▢Y ▢N
Presently in dental pain	▢Y ▢N	Pain, tenderness or noise in either jaw	▢Y ▢N	Floss daily	▢Y ▢N
Unfavourable reaction to dentistry	▢Y ▢N	Grind or clench teeth	▢Y ▢N	Flouride treatments	▢Y ▢N
Missing or extra permanent teeth	▢Y ▢N	Frequent sore throats	▢Y ▢N	Frequently chew gum	▢Y ▢N
Injury to face, jaw, teeth or mouth	▢Y ▢N	Speech problems	▢Y ▢N	Requires premedication	▢Y ▢N
Bleeding gums	▢Y ▢N	Frequent headaches	▢Y ▢N		
Oral habits	▢Y ▢N	Snores during sleep	▢Y ▢N	Pregnant	▢Y ▢N
Mouth breathing	▢Y ▢N	Neck/Shoulder pain		Menstruation started	▢Y ▢N

Patient/Responsible Party Signature 1 ______ Date ______

Responsible Party Signature 2 ______ Date ______