ORTHO - NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): _____

PREFERRED NAME: _____

BIRTHDATE (DD/MM/YY): _____ SEX/GENDER: _____

HOME ADDRESS (Nº, STREET, CITY, PROVINCE): _____

_____

POSTAL CODE: _____ HOME PHONE: _____ OTHER PHONE: _____

CONTACT EMAIL: _____

What is your main concern? (Reason for Orthodontic Consultation) _____

_____

Who can we thank for referring you to our office? _____

Have you had an orthodontic consultation before? ..... Yes ☐ No ☐

If yes, please explain: _____

Have you had an orthodontic treatment before ..... Yes ☐ No ☐

If yes, please explain: _____

Do you have any family members that have had an orthodontic treatment? ..... Yes ☐ No ☐ N/A ☐

If yes, please explain: _____

Please list all family members who had an orthodontic treatment and the specific treatment they received.

_____

PARENT/GUARDIAN 1 INFORMATION

NAME (SURNAME, GIVEN) PHONE:

_____

Is the parent/guardian's address the same as the child's address? ..... Yes ☐ No ☐ N/A ☐

ADDRESS (NO, STREET, CITY, PROVINCE): WORK PHONE:

_____

EMAIL ADDRESS: _____

PARENT/GUARDIAN 2 INFORMATION

NAME (SURNAME, GIVEN) PHONE:

_____

Is the parent/guardian's address the same as the child's address? ..... Yes ☐ No ☐ N/A ☐

ADDRESS (NO, STREET, CITY, PROVINCE): WORK PHONE:

_____

EMAIL ADDRESS: _____

IS FINANCIALLY RESPONSIBLE FOR THIS CHILD:

Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Both ☐ Myself ☐ Other ☐ _____

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INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING):

SUBSCRIBER:	RELATION:	INSURANCE CO:
POLICY PLAN#:	DIVISION/SECT.#:	SUBSCRIBER CO:
SUBSCRIBER (SECONDARY)	RELATION:	INSURANCE CO:
POLICY PLAN#:	DIVISION/SECT.#:	SUBSCRIBER CO:

FAMILY DENTIST: DATE OF LAST VISIT:

What treatment did you receive?

FAMILY PHYSICIAN: DATE OF LAST VISIT:

NAME OF MEDICAL SPECIALIST: AREA OF SPECIALTY:

PHONE OR ADDRESS:

MEDICAL HISTORY

Please indicate if you have any of the following conditions for which you have been treated.

- ☐ Fainting/Dizzy spells
- ☐ Eating disorder
- ☐ Stroke/TIA
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Asthma or Emphysema
- ☐ Pacemaker
- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Steroid therapy
- ☐ Diabetes
- ☐ Stomach ulcers
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Arthritis/Rheumatism
- ☐ Seizures/Epilepsy
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Hyper/Hypoglycemia
- ☐ Mental or Nervous disorder
- ☐ Circulatory problems
- ☐ Blood transfusion
- ☐ Other communicable disease/ Transmissible infection
- ☐ Chest pain/Angina/Heart attack
- ☐ Drug/Alcohol/Cannabis use or dependency
- ☐ Shortness of breath
- ☐ Osteoporosis

Please provide details on any conditions selected above.

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MEDICAL HISTORY (PLEASE SELECT YES OR NO TO EACH QUESTION)

1. Do you have any health problems? ..... Yes ☐ No ☐
   If yes, please provide details:

2. Do you have any history of major illness? ..... Yes ☐ No ☐
   If yes, please explain:

3. Are you taking any drugs or medication? ..... Yes ☐ No ☐
   If yes, please explain: _____

4. Are you allergic or sensitive to any drugs? ..... Yes ☐ No ☐
   If yes, please explain:

5. Are you allergic to latex or any other products? ..... Yes ☐ No ☐
   If yes, please explain:

6. Do you need to take pre-medication (e.g. antibiotics) before dental treatment? ..... Yes ☐ No ☐
   If yes, please explain:

7. Do you smoke, vape, use e-cigarettes, or chew tobacco products? ..... Yes ☐ No ☐
   If yes, how many per day:

8. Have you ever had surgery or been hospitalized? ..... Yes ☐ No ☐
   If yes, please explain:

9. Have you gained or lost a lot of weight recently? ..... Yes ☐ No ☐
   If yes, please explain:

10. Are you pregnant? ..... Yes ☐ No ☐
11. Are you breastfeeding? ..... Yes ☐ No ☐
12. Are you taking birth control or hormones? ..... Yes ☐ No ☐
    If yes, please explain:

13. Are there any other medical conditions we should know about? ..... Yes ☐ No ☐

14. Please provide details of recent travels and symptoms such as a cough or illness since the travel.

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DENTAL HISTORY **(PLEASE SELECT YES OR NO, OTHER/UNSURE TO EACH QUESTION)**

HAVE YOU EVER HAD:

1. Surgical treatment or extraction? ..... Yes ☐ No ☐ Other ☐
   If yes, please explain:
   _____
2. Head trauma/ jaw fracture/ car accident? ..... Yes ☐ No ☐ Other ☐
   If yes, please explain:
   _____
3. Jaw surgery? ..... Yes ☐ No ☐ Other ☐
   If yes, please explain:
   _____
4. Gum treatment? ..... Yes ☐ No ☐ Other ☐
   If yes, please explain:
   _____
5. Have you ever experienced joint problems (TMJ)? ..... Yes ☐ No ☐ Other ☐
   If yes, please explain:
   _____

HABITS/ HYGIENE

Please check all that apply.

- ☐ Thumb/ Fingers / Object sucking
- ☐ Pens biting
- ☐ Lip biting
- ☐ Nail biting
- ☐ Nervous tic
- ☐ Tooth clenching/Bruxism
- ☐ Tongue thrust
- ☐ Mouth breathing
- ☐ Open mouth rest position
- ☐ Chewing gum
- ☐ Brushing. How many times per day? _____
- ☐ Flossing
- ☐ Flouride mouth-rinse

I, the undersigned, hereby declare that I have read, understood and answered the above medical/dental questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health. I authorize the setting up of my dental file, its follow-up as well as my registration on the recall list of the attending dentist(s). I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her auxiliary personnel will have access to it. I have also been informed of my right to consult my file, to request that it be corrected if necessary and to remove my name from the recall list.

_____ _____

(Signature) PATIENT ☐ PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

FOR THE DOCTOR'S USE ONLY

_____ _____

(Reviewed By Dentist) Date