

Please Review all Information, complete and sign, Thank you



Patient Information

Patient Name _____ Birthday ____/____/____ ☐ Male ☐ Female
Last First MI M D Y
Address _____ City _____ Prov. _____ Postal Code _____
Home Ph _____ Dentist's Name _____
Cell Ph _____ Occupation (optional) _____
Work Ph _____ Whom may we thank for referring you? _____
Email _____ Family members seen by us _____
Last First
Name of School (child) _____ Alberta Health Care # _____

Parent Information (please complete if patient is under age of 18)

Patient lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ other _____
Person responsible for Account _____ Relationship _____
Address (if different from Patient) _____ City _____ Prov _____ PC _____
Home Ph _____ Cell Ph _____ Work Ph _____
Email _____
Additional information if needed _____
Other parent/guardian name _____ Relationship _____

Insurance

Do you have Orthodontic Insurance ☐ Yes ☐ No
If yes, please see one of our Scheduling Coordinators to confirm information

Dental History

Does the patient see the dentist regularly? ☐ Yes ☐ No Date of last checkup _____
Date of last hygiene appt. _____
Has the patient now or ever experienced problems with their jaw joints (TMJ)? ☐ Yes ☐ No
If yes, please specify _____
Have there been any injuries to the face, mouth, teeth or 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 ☐ Frequent Headaches

PLEASE TURN PAGE OVER AND COMPLETE

Medical History

Medical Dr Name _____ Medical Dr Phone No _____

Is the patient currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain _____

Does the patient require antibiotics before dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Please list all prescription/over the counter drugs the patient is currently taking _____

Does the patient have any allergies? ☐ Yes ☐ No List all _____

Does the pt use tobacco? (Smoking or chewing) ☐ Yes ☐ No Is the patient pregnant? ☐ Yes ☐ No ☐ Unsure

DOES HE PATIENT HAVE OR EVER HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Anemia/Blood transfusion	☐	☐	Congenital heart defect	☐	☐	High Blood Pressure	☐	☐
Colitis/Crohns	☐	☐	Mitral Valve Prolapse	☐	☐	Hay Fever	☐	☐
Aids/HIV	☐	☐	Pacemaker/Heart attack/Stroke	☐	☐	Low Blood Pressure	☐	☐
Alcohol/Drug abuse	☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐
Arthritis	☐	☐	Emotional/Psychiatric Concern	☐	☐	Liver Disease	☐	☐
Artificial Joints	☐	☐	Emphysema	☐	☐	Asthma	☐	☐
Epilepsy/Seizures/Fainting	☐	☐	Cancer/Chemotherapy /Radiation	☐	☐	Fetal Alcohol Syndrome	☐	☐
Frequent Headaches	☐	☐	Hepatitis (type___) /Herpes	☐	☐	Lupus	☐	☐
Shingles	☐	☐	Thyroid Problems	☐	☐	Tuberculosis	☐	☐
Ulcers	☐	☐						

If yes to any of the above please explain _____

Describe any other medical condition not listed _____

Do you have a preferred type of treatment? ☐ No ☐ Yes- See Options Below



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 the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature Patient/Parent/Guardian

Date