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

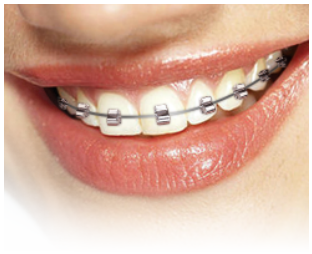
DOES HE PATIENT HAVE OR EVER HAD ANY OF THE FOLLOWING?

	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



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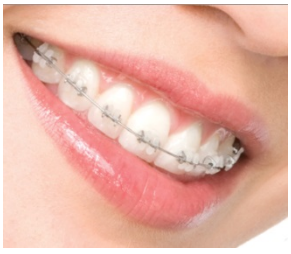

☐

invisalign

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