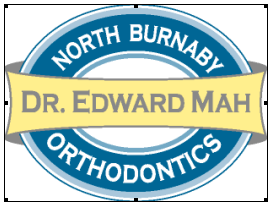
Please Print and Sign



PATIENT INFORMATION

Name: _____ Nickname: _____

Address: _____

City: _____ Postal Code: _____ No. Years at This Address: _____

Phone: (____) _____ Work: (____) _____ Email: _____

Birthdate: _____ Age: _____ Sex: ☐ M ☐ F School: _____

Hobbies/Interests: _____

Has any member of your family undergone orthodontic treatment? ☐ Yes ☐ No Name: _____

Do you know anyone being treated in this office? ☐ Yes ☐ No Name: _____

Whom may we thank for referring you? _____

Reason for seeking treatment: _____

PARENT/GUARDIAN AND FINANCIALLY RESPONSIBLE PARTIES

#1 Name: _____ Marital Status: _____

Address: _____

Phone: (____) _____ Work: (____) _____ Email: _____

Relationship to Patient: _____ Birthdate: _____

Employer: _____ Occupation: _____

Employer Address: _____

No. Years at Employer _____ S.I.N. _____ Do You Have Orthodontic Insurance? ☐ Yes ☐ No

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#2 Name: _____ Marital Status: _____

Address: _____

Phone: (____) _____ Work: (____) _____ Email: _____

Relationship to Patient: _____ Birthdate: _____

Employer: _____ Occupation: _____

Employer Address: _____

No. Years at Employer _____ S.I.N. _____ Do You Have Orthodontic Insurance? ☐ Yes ☐ No

EMERGENCY CONTACT

Name of nearest relative not living with you: _____

Address: _____

Phone: (____) _____ Work: (____) _____ Relationship to Patient: _____

OVER ⇒

DENTAL HISTORY

Dentist: _____ Last Cleaning: _____ Last X-rays: _____

Have you had any injuries to the mouth/jaw area? If yes, please explain: _____

Any pain or clicking upon mouth opening/closing? If yes, please explain: _____

Is this your first orthodontic visit? If no, please explain: _____

Reason for referral: _____

Please list any experiences or problems you would like the doctor to be aware of: _____

_____

If the patient is a child, is there any presence of: ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Mouth Breathing

HEALTH HISTORY

Physician: _____ Date of Last Visit: _____

Current medical condition(s), medication(s): _____

Have you been hospitalized in the last two years? If yes, please explain: _____

_____

Have you had... [Please check (✓) each box if the answer is "Yes", leave blank if "No"]

- ☐ Adenoidectomy
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Emotional problems
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis, type _____
- ☐ Herpes
- ☐ High/Low blood pressure
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Nervous problems
- ☐ Pregnant, due date _____
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling in ankles or feet
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tobacco use, all forms
- ☐ Tonsillectomy
- ☐ Transplanted organs
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers, stomach
- ☐ Venereal disease
- ☐ Weight change, unexplained

Other health complications not listed above: _____
If the patient's medical status changes, please notify us as soon as possible.

Are you allergic to:

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Sulfa
- ☐ Latex
- ☐ Nickel
- ☐ Local anesthetic
- ☐ Other: _____

Name of responsible party: _____ Relationship: _____

Signature of responsible party: _____ Please Print and Sign Date: _____