

Patient Information *To become better acquainted and to be able to offer you the best possible care, we ask that you complete this information form.*

Date _____ Patient's Age _____

Patient's Name _____ Birthday ____/____/____ Male Female
Last First MI M D Y

Address _____ City _____ Prov _____ PC _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Employer (Optional) _____

Dentist's Name _____ Family members seen by us _____

Whom may we thank for referring you? Dentist Friend Family Member Oasis Staff Sign/Billboard Website
 Advertisement _____ Other _____
(please elaborate) (please elaborate)

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

Patient lives with: Mother Father Both Parents Other (please specify) _____

Person responsible for account _____ Relation _____

Address _____ City _____ Prov _____ PC _____
(if different from the patient)

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

<p>Mother's Information <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian</p> <p>Name _____</p> <p>Address _____ (if different from patient)</p> <p>Home Phone _____</p> <p>Work Phone _____</p> <p>Cell Phone _____</p> <p>Email _____</p>	<p>Father's Information <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian</p> <p>Name _____</p> <p>Address _____ (if different from patient)</p> <p>Home Phone _____</p> <p>Work Phone _____</p> <p>Cell Phone _____</p> <p>Email _____</p>
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Insurance Information

Our office charges the patient/parent/guardian directly for all professional services rendered. We will complete the necessary forms so that you can receive the reimbursement to which you are entitled under your policy.

Do you have orthodontic coverage? Yes No Unsure

<p>Primary</p> <p>Insurance company name _____</p> <p>Group # _____ ID# _____</p> <p>Subscriber's name _____</p> <p>Subscriber's birthday ____/____/____ M D Y</p>	<p>Secondary</p> <p>Insurance company name _____</p> <p>Group # _____ ID# _____</p> <p>Subscriber's name _____</p> <p>Subscriber's birthday ____/____/____ M D Y</p>
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Do you receive funding through: Indian Affairs Social Assistance A.I.S.H. Ward of Government Cleft Palate Clinic

Dental History

Reason for orthodontic consultation (chief concern) _____

Is the patient happy with his/her smile? Yes No If not, what would he/she change? _____

Has the patient ever had or been evaluated for orthodontic treatment? Yes No

Does the patient want treatment? Yes No Unsure

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 specify _____

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

Does the patient see the dentist regularly? Yes No How often does the patient brush? _____

How often does the patient floss? _____

Medical History

Physician's Name _____ Physician's Phone # _____ Alberta Healthcare # _____

Patient's current physical health is Good Fair 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 _____

Is the patient taking any prescription or over the counter drugs? Yes No List all _____

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

Does the patient use tobacco? (smoking or chewing) Yes No

For women: Is the patient pregnant? Yes No Unsure Has the patient started her menstrual cycle? Yes No

DOES THE PATIENT HAVE NOW, OR EVER HAD ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
Anemia/Blood Transfusion/Hemoph ilia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalized for any reason	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints/bones/valves	<input type="checkbox"/>	<input type="checkbox"/>	Fetal alcohol syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease/traits	<input type="checkbox"/>	<input type="checkbox"/>
Colitis/Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect/Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			

If yes to any of the above, please explain _____

Describe any other medical condition not listed _____

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 of Patient/Parent/Guardian _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient/parent named herein.

Initial: _____ Date: _____

Comments: _____

