Oasis Wellness Centre
201 13613 163 Street NW
Edmonton, AB
T5V 0B5

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www.oasisorthodontics.ca

Patient Information

To become better acquainted and to be able to offer you the best possible care, we ask that you complete this

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 ______________________________________

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____

Mother's Information

☐ Stepmother ☐ Guardian

Name____

Address____

(if different from patient)

Home Phone____

Work Phone____

Cell Phone____

Email____

Father's Information

☐ Stepfather ☐ Guardian

Name____

Address____

(if different from patient)

Home Phone____

Work Phone____

Cell Phone____

Email____

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

Primary

Insurance company name__________________________________

Group #______________________ID#_________________________

Subscriber's name____

Subscriber's birthday_________/__________/__________________

M D Y

Secondary

Insurance company name__________________________________

Group #______________________ID#_________________________

Subscriber's name____

Subscriber's birthday_________/__________/__________________

M D Y

Do you receive funding through: ☐ Indian Affairs ☐ Social Assistance ☐ A.I.S.H. ☐ Ward of Government ☐ Cleft Palate Clinic

Continued on other side........

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?

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

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:____

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