Shuswap ORTHODONTICS
straight teeth | great bite | beautiful smile

PATIENT INFORMATION **Today's Date: _____**

Patient's Name: _____

(Preferred to be called: _____) DOB: _____ Age: _____ Sex: _____

Phone: Primary # H C W _____ 2nd # H C W_____ 3rd # H C W_____

Cell Provider:_____ Preferred method(s) of confirmation: Text_____ Email_____ Phone_____

Email _____

Address: _____ City: _____ PC: _____

School: _____ Grade: _____

Patient's Physician: _____ Patient's Dentist: _____

Names & ages of other children in family: _____

Names of other family members in our orthodontic practice: _____

_____

RESPONSIBLE PARTIES Adult Patients: Please complete this form for yourself & your spouse.
Parents: If completing this form for a minor, please complete parental information

Mother/ Wife/ Self

Name: _____ DOB: _____

Address: _____ City: _____PC: _____

Primary Phone #: _____ Relationship to patient: _____

Orthodontic Insurance: Y N

Father/ Husband/ Self

Name: _____ DOB: _____

Address: _____ City: _____PC: _____

Primary Phone #: _____ Relationship to patient: _____

Orthodontic Insurance: Y N

MEDICAL HISTORY

	YES	NO	
1.	☐	☐	Does the patient smoke?
2.	☐	☐	Is the patient presently under the care of a physician for a major illness?
3.	☐	☐	Does the patient have any history of a major illness?
4.	☐	☐	Is the patient in good health?
	☐	☐	Has the patient had their tonsils (circle) or adenoids (circle) removed? What age? _____
5.	☐	☐	If not removed, does the patient have regular problems with their tonsils or adenoids?
6.	☐	☐	Does the patient have a tendency to: Colds ☐ Sore throats ☐ Ear Infections ☐
7.	☐	☐	Female patients: Are you pregnant?
8.	☐	☐	If a child: Has the patient reached puberty?
9.	☐	☐	Is the patient currently taking any medications? Please list: _____
10.	☐	☐	Does the patient have any physical or emotional limitations?
11.	☐	☐	Does the patient have learning or psychological disabilities or need extra help with instructions?

12. Check the box if the patient had (or have) any problems with any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Bleeding	☐	☐	Nervous Disorders	☐	☐	Bone Disorders
☐	☐	Rheumatic Fever	☐	☐	Pneumonia	☐	☐	Asthma
☐	☐	Heart Trouble	☐	☐	Anemia	☐	☐	Diabetes
☐	☐	Heart Valves	☐	☐	Fainting / Dizziness	☐	☐	Kidney Disease
☐	☐	Hemophilia	☐	☐	Liver Disease	☐	☐	Cleft Lip / Palate
☐	☐	Heart Murmur	☐	☐	Hearing	☐	☐	Epilepsy

☐ ☐ Has the patient been advised to take antibiotics prior to dental visits?
If so, by what doctor? (name & phone number) _____

13. Does the patient have or has the patient been exposed to any of the following?

YES	NO		YES	NO	
☐	☐	Hepatitis	☐	☐	HIV Positive / AIDS
☐	☐	Tuberculosis	☐	☐	STD's

14.	☐	☐	Does the patient have allergies to any drugs? Please list: _____
15.	☐	☐	Does the patient have any other allergies? Please list: _____

Describe any other medical problems not yet covered:

_____

_____

_____

_____

DENTAL HISTORY

	YES	NO	
16.	☐	☐	Does the patient (or parent of the patient) have a concern regarding the appearance of the face? If yes, please describe: _____
17.	☐	☐	Has the patient been told that they have an underbite?
18.	☐	☐	Is there a known family history of any family member with an underbite? If yes, what is the relationship to the patient? _____
19.	☐	☐	Has there been any injuries to the face, teeth, or jaw joints? When? _____
20.	☐	☐	Does the patient have speech problems? Any previous therapy? _____
21.	☐	☐	Has the patient ever sucked the thumb or fingers? Until what age? _____
22	☐	☐	Does the patient snore while sleeping?
23.	☐	☐	Does the patient breathe through the mouth rather than the nose? ☐ Sometimes ☐ Usually
24.	☐	☐	Are there any diagnosed or suspected airway/breathing problems?
25.	☐	☐	Has the patient ever been informed of any missing permanent teeth?
26.	☐	☐	Has the patient previously had an orthodontic consultation? When? _____
27.	☐	☐	Has the patient ever had orthodontic treatment? When? _____ What type of orthodontic treatment? _____
28.	☐	☐	Has either parent had orthodontic treatment? Which? _____
29.	☐	☐	Does the patient have pain in the jaw joint?
30.	☐	☐	Does the patient have clicking in the jaw joint? How often? _____
31.	☐	☐	Does the patient clench and / or grind the teeth?
32.	☐	☐	Has the patient ever been diagnosed as having jaw joint (TMJ) problems? When? _____
33.	☐	☐	Does the patient place objects (pens, pencils, etc.) in the mouth?
34.	☐	☐	Does the patient play a contact sport? Which? _____
35.	☐	☐	Does the patient play a musical instrument? Which? _____
36.	☐	☐	Has the patient been seen by their dentist recently? When? _____ What was done? _____ When are they scheduled to return? _____ How often does the patient see their dentist? _____
37.	☐	☐	What is the reason for this consultation? _____

We always appreciate the referral of patients to our office and like to thank those who have made the referral. Whom may we thank for referring you to our office?

_____

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent.

Signature: _____

Date: _____

Relationship to patient: _____

Legal Guardian (if different): _____