Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other:____________

Patient's Name:____
(First) (Middle) (Last)

Name Commonly Used:_________________ Sex:____ Age:____ Date of Birth:_____/____/_____
MM / DD / YYYY

Marital Status:________________________

Address:____

City:______________________ Province:_____________ Postal Code:___________

Home Phone:_________________ Cell Phone:__________________ Work Phone:______________

Email Address:____

Employer:____________________________________ Occupation:_________________________

Person Responsible for account:____

Preferred Method of Correspondence: ☐ Email ☐ Canada Post

Who noticed the orthodontic problem? ☐ Self ☐ Dentist ☐ Other____________________________

Please describe your orthodontic concern(s) in your own words:__________________________________

____

What concerns you most about the thought of orthodontic treatment?

☐ Appearance of Appliances ☐ Cost ☐ Length of time ☐ Discomfort ☐ Results ☐ Other

Who may we thank for referring you to our office?____

Do you have any friends/relatives who we are treating in our office? ☐ No ☐ Yes:__________________

Are you interested in (please indicate all that apply):

☐ Information ☐ Treatment at this time ☐ Clarification of previously received or conflicting information

Insurance Information

Please note: Our office charges the patient directly for all professional services rendered and we are unable to accept assignment from your insurance carrier. However, we will be happy to assist you with your dental claim form.

Insurance Company Name 1:____

Policy Number:______________________ Identification Number:__________________

Policy Holder's Name:____

Policy Holder's Date of Birth:_____/____/_____
MM / DD / YYYY

Insurance Company Name 2:____

Policy Number:______________________ Identification Number:__________________

Policy Holder's Name:____

Policy Holder's Date of Birth:_____/____/_____
MM / DD / YYYY

Consent for Email Communication

As per the Canadian Anti-Spam Legislation, I am providing my Express Consent to communicate electronically. I understand that my consent may be withdrawn at any time by informing Forst Orthodontics of my request.

Name:____
(First) (Middle) (Last)

Email address:____

Please confirm your consent to receive electronic communications from Forst Orthodontics:

☐ Yes, I do give consent ☐ No, I do not give consent

Signature:____ Date:_____/____/_____
MM / DD / YYYY

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept confidential.

Patient Medical History

Physician's Name:__________________________________ Physician's Phone:____________________

Physician's Address:____

Have you experienced any health problems? ☐ No ☐ Yes

(If yes, please explain)____

Any major changes in your health recently? ☐ No ☐ Yes

(If yes, please explain)____

Are you currently taking any medications? ☐ No ☐ Yes

(If yes, please explain)____

Are you allergic to any medications? ☐ No ☐ Yes

(If yes, please explain)____

Have your tonsils and/or adenoids been removed? ☐ No ☐ Yes

(If yes, please explain)____

Please check if you have had any of the following conditions:

Heart Murmur ☐ No ☐ Yes	**Rheumatic Fever** ☐ No ☐ Yes	**Prolonged Bleeding** ☐ No ☐ Yes	**Developmental Disorder** ☐ No ☐ Yes
Hepatitis ☐ No ☐ Yes	**Kidney Disease** ☐ No ☐ Yes	**Respiratory Allergies** ☐ No ☐ Yes	**Radiation/Chemotherapy** ☐ No ☐ Yes
Bone Disorders ☐ No ☐ Yes	**Cancer** ☐ No ☐ Yes	**Growth Disorders** ☐ No ☐ Yes	**Tonsillitis** ☐ No ☐ Yes
Heart Surgery ☐ No ☐ Yes	**Endocrine Disorders** ☐ No ☐ Yes	**Hives/Rash** ☐ No ☐ Yes	**Anemia, Blood Disorders** ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes	**Epilepsy** ☐ No ☐ Yes	**Asthma** ☐ No ☐ Yes	**Cleft Lip and/or Palate** ☐ No ☐ Yes

Is there any other condition, allergy or problem that you think we should know about? ☐ No ☐ Yes

(If yes, please explain)____

Dental History

Dentist's Name:________________________ Practice Name:_________________________________

Dentist's Address:____________________________________ Dentist's Phone:__________________

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists

Date of last dental visit: _____________________ Last dental x-rays:___________________________

Is there any unfinished care to be completed with your dentist? ☐ No ☐ Yes, explain________________

Are you frightened about dental treatment? ☐ No ☐ Yes, explain_______________________________

Have you had any facial or dental injuries? ☐ No ☐ Yes, explain________________________________

Have you consulted an orthodontist previously? ☐ No ☐ Yes
If yes, please explain, and indicate with whom____

Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes, explain____________________

Have you had any previous orthodontic treatment? ☐ No ☐ Yes, explain_________________________

Are you satisfied with your prior orthodontic treatment? ☐ No ☐ Yes, explain_____________________

Have you noticed any change in your bite or dental alignment recently? ☐ No ☐ Yes
If yes, please explain____

Please check if there is a history of any of the following conditions:

☐Clenching teeth ☐Muscular soreness around head and neck ☐Jaw joint soreness
☐Jaw joint popping ☐Headaches (more than normal) ☐Grinding teeth
☐Jaw joint clicking ☐Ringing in the ears ☐Speech Problems

Is there a history of mouthbreathing? ☐ No ☐ Yes, explain__________________________________

Is there any other information that might be helpful?____

Concerns

What are the chief concerns you have, related to the position of your teeth or bite?

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability ☐ Other

Please elaborate:____

____

What concerns has your dentist(s) expressed concerning your bite or dental alignment?

☐Difficulty with cleaning related to alignment of teeth ☐Wear or fractures of teeth
☐Jaw joint or muscle tightness or discomfort ☐Bone or gum loss
☐Alignment of teeth prior to restorative dental work ☐Other