FIRST ORTHODONTICS

Patient Information

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

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

Address:_____

City:_____ Province:_____ Postal Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Preferred Method of Correspondence: ☐ Email ☐ Canada Post

Patient Resides With: ☐ Both Parents ☐ Mother ☐ Father ☐ Joint Custody ☐ Other:_____

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

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

Patient's Interests:_____

Please describe your child's orthodontic concern(s) in your own words:_____

_____

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

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

Would you prefer that facial appearance **NOT** be discussed in front of your child?

☐ Yes, please do NOT discuss ☐ No, please feel free to discuss

Is there any significant family history of jaw or teeth problems?

☐ No ☐ Yes (If so, please explain)_____

Are you interested in improving the appearance of the teeth at this time even if more treatment will be required later?

☐ Yes ☐ No

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Parent's Information

Parent 1:

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

Name:_____
(First) (Middle) (Last)

Parent's Marital Status:_____

Address (if different than patient):_____

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

Parent 2:

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

Name:_____
(First) (Middle) (Last)

Parent's Marital Status:_____

Address (if different than patient):_____

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

FORST
ORTHODONTICS

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

FIRST ORTHODONTICS

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:_____

Has your child experienced any health problems? ☐ No ☐ Yes

(If yes, please explain)_____

Any major changes in your child's health recently? ☐ No ☐ Yes

(If yes, please explain)_____

Is your child taking any medications? ☐ No ☐ Yes

(If yes, please explain)_____

Is your child allergic to any medications? ☐ No ☐ Yes

(If yes, please explain)_____

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

(If yes, please explain)_____

Please check if your child has 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)_____

FIRST ORTHODONTICS

Growth Information for Patients Under 16 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives.

Has your son or daughter reached puberty? ☐ No ☐ Yes

Girls – Has she started menstruation? ☐ No ☐ Yes If yes, when:_____

Boys – Has his voice changed? ☐ No ☐ Yes If yes, when:_____

Child's Height: ___ft ___inches Father's Height: ___ft ___inches Mother's Height: ___ft ___inches

Do you feel growth is complete? ☐ No ☐ Yes If yes, explain:_____

Have parents and/or siblings had orthodontic treatment? ☐ No ☐ Yes If yes, who:_____

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 child's dentist? ☐ No ☐ Yes, explain_____

Has your child had any facial or dental injuries? ☐ No ☐ Yes, explain_____

Is there a history of thumb or finger sucking? ☐ No ☐ Yes, explain_____

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

Have you consulted an orthodontist regarding your child previously? ☐ No ☐ Yes
If yes, please explain, and indicate with whom_____

Has your child had any previous orthodontic treatment? ☐ No ☐ Yes, explain_____

Are you satisfied with your child's prior orthodontic treatment? ☐ No ☐ Yes, explain_____

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

Please check if your child has had 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?_____