BRACES4ALL® ORTHODONTICS

ADULT PATIENT INFORMATION

Phone: 780-960-1910 | Fax: 780-960-1499 | braces4all.ortho@gmail.com

Welcome to our Office

[ ] Mrs. [ ] Miss. [ ] Ms. [ ] Dr. [ ] Mr. [ ] Other _____

Patient's Name:_____ Prefers to be called:_____ Sex:_____

Address:_____ City:_____ Prov:_____Postal Code:_____

Home Phone:_____Cell:_____ Age:_____ DOB:_____

Patients E-mail:_____ Preferred method of Correspondence: [ ] E-Mail [ ] Canada Post

Who noticed the orthodontic problem? [ ] Self [ ] Dentist [ ] Other_____

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

Who may we thank referring you to our office?_____

Family and Account Information

Patient's Employer:_____Work #:_____

[ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single [ ] Common-law [ ] Other:_____

Spouse"s Name:_____Cell#:_____

Person responsible for account:_____

Please note: We can assist you with your dental claim form. If you have **orthodontic benefits** please complete below.

1. Ins.Co Name:_____
   Policy Number:_____
   Identification #:_____
   Policy Holder's Name: _____
   Policy Holder's DOB: _____
   Employer: _____

2. Ins. Co. Name:_____
   Policy Number: _____
   Identification #: _____
   Policy Holder's Name: _____
   Policy Holder's DOB: _____
   Employer: _____

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

MEDICAL HISTORY

Physician's Name:_____ Address:_____ Phone:_____

Have you experienced any health problems?	[ ] No	[ ] Yes	Explain: _____
Any major change in your health recently?	[ ] No	[ ] Yes	Explain: _____
Are you currently under a physician's care?	[ ] No	[ ] Yes	Explain: _____
Are you currently taking any medications?	[ ] No	[ ] Yes	Explain: _____
Are you allergic to any medications?	[ ] No	[ ] Yes	Explain: _____
Have you ever received a blood transfusion?	[ ] No	[ ] Yes	Explain: _____
Have your tonsils and/or adenoids been removed?	[ ] No	[ ] Yes	Explain: _____
Have you been in a risk group for HIV?	[ ] No	[ ] Yes	Explain: _____

Women only: Are you pregnant or think you may be pregnant? What month?:_____

Are you on birth control? Specify type: _____

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

Heart Murmur	[ ] No [ ] Yes	Hepatitis	[ ] No [ ] Yes	Emotional Problems	[ ] No [ ] Yes
Heart Surgery	[ ] No [ ] Yes	Diabetes	[ ] No [ ] Yes	Nervous/Anxious	[ ] No [ ] Yes
Rheumatic Fever	[ ] No [ ] Yes	Kidney Disease	[ ] No [ ] Yes	Cancer	[ ] No [ ] Yes
Endocrine Disorders	[ ] No [ ] Yes	Tuberculosis	[ ] No [ ] Yes	Bone Disorders	[ ] No [ ] Yes
Prolonged Bleeding	[ ] No [ ] Yes	Bronchitis	[ ] No [ ] Yes	Growth Disorders	[ ] No [ ] Yes
Anemia,Blood Disorders	[ ] No [ ] Yes	Asthma	[ ] No [ ] Yes	Herpes (Fever Blisters)	[ ] No [ ] Yes
Development Disorder	[ ] No [ ] Yes	Epilepsy	[ ] No [ ] Yes	Tonsillitis	[ ] No [ ] Yes
Hives / Rash	[ ] No [ ] Yes	Fainting	[ ] No [ ] Yes	Respiratory Allergies	[ ] No [ ] Yes

Is there any other condition, allergy or problem that you think we should know about? _____

_____

DENTAL HISTORY

Dentist's Name:_____ Address:_____ Phone:_____

Dental Specialist's Name:_____Phone:_____

Frequency of Dental checkups:[ ] Twice a year [ ] Once a year[ ] Only if a problem exists Date of last visit:

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 an unpleasant experience in a dental office?	[ ] No	[ ] Yes	Explain: _____
Have you had any facial or dental injuries?	[ ] No	[ ] Yes	Explain: _____
Have teeth (either primary or permanent) been removed?	[ ] No	[ ] Yes	Explain: _____
Have you consulted an orthodontist previously?	[ ] No	[ ] Yes	Explain: _____
Have you consulted an orthodontic treatment?	[ ] No	[ ] Yes	Explain: _____
Are you satisfied with your previous orthodontic treatment?	[ ] No	[ ] Yes	Explain: _____
Have you noticed any change in your bite or dental alignment recently?	[ ] No	[ ] Yes	Explain: _____

Please check if there is a history of:

[ ] Clenching teeth [ ] Muscular soreness around head & neck [ ] Jaw joint soreness [ ] Jaw joint popping

[ ] Grinding teeth [ ] Headaches (more than normal) [ ] Jaw joint clicking [ ]Ringing in the ears

[ ] Speech problems (if so which sounds?)_____ Mouth breathing: Awake_____ Asleep_____

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

[ ] Aesthetic [ ] Cleaning [ ] Comfort [ ] Ability to chew [ ] Stability

Please elaborate:_____

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

[ ] Wear or fractures of teeth [ ] Difficulty with cleaning related to alignment of teeth [ ] Bone or gum loss

[ ] Jaw joint or muscle tightness/discomfort [ ] Alignment of teeth prior to restorative dental work (crowns, bridges, etc.) [ ] Other: _____

Notes

_____

_____

Patient Signature: _____ Date: _____ Office review by: _____