Emergency Treatment Form

Date_____ Patient ID _____

Patient Information

Patient Name: _____ Gender: M / F Greeting: _____
(Dr. Mr. Mrs. Ms. Miss) First Last I prefer to be called

Street: _____ City: _____ Prov.: _____ PC: _____
Postal Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ (MM / DD / YY) Age: _____ Email: _____

School/Employer: _____ Family Doctor: _____

Dentist: _____ Orthodontist: _____

Emergency Contact Name / Number: _____ _____

Person responsible for the account: _____ Relationship to patient: _____
(Dr. Mr. Mrs. Ms. Miss) First Last

Responsible Party Information (Please complete if patient is not responsible for account)

Patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Shared between Mother & Father ☐ Other: _____

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Single ☐ Widowed

☐ Mother ☐ Stepmother ☐ Guardian

Name: _____
Address: _____
_____
(If different from patient)
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

☐ Father ☐ Stepfather ☐ Guardian

Name: _____
Address: _____
_____
(If different from patient)
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Signatures / Revisions

I certify that I have read and understand the information contained on the Emergency Treatment Form and Dental/Medical History Form, and to the best of my knowledge the information provided is correct and accurate.

Patient/Parent/Guardian Signature: _____ Date: _____

1st Medical Revision (staff use only)

Date: _____ (MM / DD / YY) Medical Changes Y / N _____

_____

Allergies: _____

Medications: _____

Patient/Parent Initials: _____ Staff Initials: _____ ____

2nd Medical Revision (staff use only)

Date: _____ (MM / DD / YY) Medical Changes Y / N _____

_____

Allergies: _____

Medications: _____

Patient/Parent Initials: _____ Staff Initials: _____ ____

Please complete reverse side

Dental History

Reason for orthodontic visit: _____

_____

_____

When were the patient's braces placed? _____

When was the patient's last visit to the dentist? _____

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

If yes, please specify: _____

_____

Does the patient presently have clicking/locking/discomfort in jaw joints near ears? ☐ Yes ☐ No

Does the patient smoke and/or vape? ☐ Yes ☐ No

Does the patient chew tobacco products? ☐ Yes ☐ No

Does the patient use recreational drugs? ☐ Yes ☐ No

On average, how much alcohol does the patient consume per week? _____

Medical History

Is the patient in good health? ☐ Yes ☐ No

Does the patient presently have, or ever had any of the following?

ADD/ADHD	☐ Yes ☐ No	Endocrine disorders	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Environmental allergies	☐ Yes ☐ No	Latex allergy	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Epilepsy/seizures	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Artificial joints/bones/valves	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fetal Alcohol Syndrome	☐ Yes ☐ No	Metal allergy	☐ Yes ☐ No
Bone disorders/bone loss	☐ Yes ☐ No	Growth problems	☐ Yes ☐ No	Nervous disorders	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart trouble	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Canker sores	☐ Yes ☐ No	Congenital heart defect	☐ Yes ☐ No	Prolonged bleeding	☐ Yes ☐ No
Chemo/radiation therapy	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Rheumatic/scarlet fever	☐ Yes ☐ No
Cleft palate	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold sores	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Ulcers/colitis	☐ Yes ☐ No
Emotional problems/anxiety	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Venereal disease	☐ Yes ☐ No

If yes to any of the above, please explain: _____

_____

Describe any other medical condition not listed: _____

_____

Does the patient require antibiotics for dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

List any other allergies or drug sensitivities: _____

List any drugs or medication now being taken: _____

Any serious illnesses or recent hospitalizations? _____

Female patients only: Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Consent for Orthodontic Treatment

By signing below, I consent to orthodontic procedures deemed necessary by Dr. Kaller:

_____

Patient (or Guardian) Signature

Notes: _____

_____