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K9H 1Y6

Kawartha ORTHODONTICS
Certified Orthodontic Specialists

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Date_____

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: _____ Spouse: _____

Other immediate family members seen by us: _____

Whom may we thank for referring you to our office? ☐ Dentist ☐ Friend ☐ Family Member ☐ Website ☐ Other: _____

Dentist: _____ Family Doctor: _____

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 Patient Information 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 consultation (chief concern): _____

Has the patient ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Has the patient ever had orthodontic treatment? ☐ Yes ☐ No

If yes, please specify name of orthodontist: _____

Has anyone else in the family had a similar orthodontic problem? ☐ Yes ☐ No

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

Have x-rays been taken recently? ☐ Yes ☐ No

Has the patient been informed of any missing permanent teeth? ☐ Yes ☐ No

Has the patient been informed of any extra teeth? ☐ Yes ☐ No

Have any teeth been removed by the dentist? ☐ Yes ☐ No

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

If yes, please specify: _____

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

Thumb/finger sucking	☐ Yes ☐ No		Snoring	☐ Yes ☐ No	
Lip/nail biting	☐ Yes ☐ No		Tongue thrusting	☐ Yes ☐ No	
Clenching/grinding	☐ Yes ☐ No		Mouth breathing	☐ Yes ☐ No	

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

Tonsils removed	☐ Yes ☐ No		Speech problems	☐ Yes ☐ No	
Adenoids removed	☐ Yes ☐ No		Chewing/eating problems	☐ Yes ☐ No	
Frequent earaches	☐ Yes ☐ No		Frequent headaches	☐ Yes ☐ No	

Clicking/locking/discomfort in jaw joints near ears ☐ Yes ☐ No

Frequent colds, sore throats, ear infections ☐ Yes ☐ No

Does the patient:

Smoke and/or vape? ☐ Yes ☐ No

Chew tobacco products? ☐ Yes ☐ No

Use recreational drugs? ☐ Yes ☐ No

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

_____

Medical History

Is 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? _____

Is the patient noticeably growing in height? ☐ Yes ☐ No

Has the patient's shoe size changed recently? ☐ Yes ☐ No

Has the patient started puberty? ☐ Yes ☐ No

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