NORTH YORK orthodontics

Child

PLEASE PRINT CLEARLY

Name: Last_____ First _____ Sex: M ◯ F ◯

D.O.B: M_____D_____Y_____ Age:_____

Address:_____

City :_____ Postal Code: _____

MOTHER

Name:_____Occupation/Employer_____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Email:_____

FATHER

Name:_____Occupation/Employer_____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Email:_____

Dentist: _____ Physician: _____

Orthodontic Insurance : ◯Yes ◯ NO

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

Medical History:

Do You have a Latex or Nickel allergy?

Yes No

◯ ◯ Heart Trouble (Angina, High blood pressure, Heart Murmur, Rheumatic Fever)
◯ ◯ Any Artificial Valve, Joint , Prosthesis , or Stent /Shunts?
◯ ◯ Breathing Problems (Asthma, Emphysema, Tuberculosis, Sleep apnea)
◯ ◯ Allergies : Please specify_____
◯ ◯ Diabetes, Thyroid Disease, or Arthritis
◯ ◯ Blood Problems (Bleeding disorders, Anemia, Sickle cell anemia, Hemophilia)
◯ ◯ Infectious disease (Hepatitis, HIV/AIDS, Herpes)
◯ ◯ Nervous disorder (Psychiatric treatment, Addictions, ADD/ADHD)
◯ ◯ Stroke or Epilepsy
◯ ◯ Smoker?(How much do you smoke per day): _____

Please list all your medications:_____

For Females: has menstruation started yet? ◯ Yes ◯ No

Dental History:

Yes	No	
◯	◯	Have you had previous dental care? When? _____
◯	◯	Have you ever had periodontal (gum) treatment, Bleeding gums, Bad breath, Mouth odor?
◯	◯	Do you gag easily?
◯	◯	Do you have/had any thumb or finger sucking habit or an abnormal swallowing habit (Tongue thrusting)?
◯	◯	Any mouth breathing, snoring, difficulty in breathing?
◯	◯	Any tooth grinding, jaw clenching, clicking, locking, or any difficulty in chewing or Jaw opening?
◯	◯	Any injuries to face, teeth or mouth? Any chipped or otherwise injured permanent teeth?
◯	◯	Are you concerned about spaced, crooked, protruding teeth?
◯	◯	Are you concerned about under or over developed jaw?
◯	◯	Any relative with similar tooth or jaw relationships?
◯	◯	Have you had any Previous orthodontic treatment? When?_____

Please specify any other information you would think can be helpful to your treatment._____

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I, the undersigned, certify that I have read and understand the above medical and dental information, if there are any later charges to my clinical history. I recognize that is my responsibility to inform this office. I also give permission for clinical examination.

I consent to your collection of any and all personal information about me including my personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purposes whatsoever, but only in the course , of, concerning , or relation to , your dental practice , North York Orthodontics . I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Profession, the Dentistry acts of Ontario, and to any insurer, other payment organization who may be responsible for payment of all or a part of any treatment or service that you provide

_____ _____

Signature of Patient, Parent or Guardian Date