NORTH YORK orthodontics

Patient Information - Adult

Last name	First name	Date of Birth (d/m/yr)	Age	Home Phone

Home Address	City	Postal Code	Email Address

Occupation/Employer	Work Address	Work Phone	Cell Phone

Spouse's Name	Spouse's Occupation/Employer	Spouse's Work Phone

Dentist	Physician	Referred By

Dental Insurance	Group Policy Number	Certificate or ID Number

Medical History: Have you ever had or been treated for: (please circle)

Cancer	Rheumatic Fever	Blood Pressure	Thyroid Problem	Anemia
Blood disorders	Asthma	Diabetes	Heart Trouble	Sinusitis
Tuberculosis	Epilepsy	Hay fever	Other S.T.D.'s	A.I.D.S.
Allergies	Hepatitis	Heart Murmur	Osteoporosis	Other Illness

Please provide necessary details: _____

_____

For females: Are you or do you suspect being currently pregnant? ☐ **Yes** ☐ **No**

Dental History:

1. Have you had previous dental care? ..... Yes No
2. Have you ever had periodontal (gum) treatment? ..... Yes No
3. Do you have bleeding gums, bad breath, mouth odor? ..... Yes No
4. Do you have/had any thumb or finger sucking habit? ..... Yes No
5. Any abnormal swallowing habit (tongue thrusting)? ..... Yes No
6. Any mouth breathing, snoring, difficulty in breathing? ..... Yes No
7. Any tooth grinding, jaw clenching, clicking, locking? ..... Yes No
8. Any pain in jaw or ringing in the ears? ..... Yes No
9. Any difficulty encountered in chewing or jaw opening? ..... Yes No
10. Are you concerned about spaced, crooked, protruding teeth? ..... Yes No
11. Do you have any chipped or otherwise injured permanent teeth? ..... Yes No
12. Are you concerned about under or over developed jaw? ..... Yes No
13. Any relative with similar tooth or jaw relationships? ..... Yes No
14. Have you had any previous orthodontic treatment? ..... Yes No
15. Have you had an accident or trauma to face/head/teeth? ..... Yes No

Signature _____ Date_____