Sharp Orthodontics

Certified Specialists in Orthodontics

GENERAL INFORMATION

Appointment. Date:.....

Patient's name:..... Preferred name: .....
Birthdate: ..... Age:..... Sex: .....
Address: .....
Postal code: ..... Telephone: .....
Dentist: ..... Physician:.....
Whom can we thank for referring you to see us?..... .....
School: ..... Grade: .....

Father's name: ..... Mothers name: .....
Occupation:: ..... Occupation: .....
Employed by:..... Employed by:.....
Telephone:..... Telephone: .....
Individual responsible for account: .....
Email:.....

Do you have orthodontic insurance? ..... Insurance company: .....
Name of Subscriber:..... Subscriber Birthdate:.....
Relationship to patient:.....
Address (if different from above):.....
Group policy: ..... Certificate no.:.....
S.I.N. or Identity no.: ..... Dependent no.: .....

GENERAL HEALTH QUESTIONNAIRE

Please indicate if the patient is affected by any of the following conditions.

__Diabetes
__Asthma or other respiratory condition
__Rheumatic fever
__Convulsions
__Kidney disease
__Heart disease
__Bone disorders
__Tuberculosis
__Fainting and / or dizziness
__Frequent headaches and / or neck aches
__Chronic illness
__Ever been hospitalized
__Anemia
__Bleeding problems
__Liver disease / hepatitis
__Nervous disorders
__Frequent cold sores or canker sores
__Shortness of breath or chest pains
__High blood pressure
__Cancer
__AIDS
__Arthritis
__Birth defects
__Breathes mainly through mouth
__Tendency to colds, sore throats, or ear infections (please circle)
__Removal of tonsils and adenoids. What age? ____
__Allergies or drug sensitivities. Specify:.....
__Taking medications now. Specify:.....

ORTHODONTIC PATIENT HISTORY

Please indicate which of the following, if any, are cause of concern relating to this orthodontic consultation.

__Protruding teeth
__Crowded teeth
__Spaces teeth
__Missing teeth
__Irregularly placed teeth
__Appearance of lips / mouth
__Shows too much gum tissue
__Teeth erupting in wrong position
__Lip biting or sucking
__Grinding or clenching teeth
__Some teeth have not erupted
__Impacted teeth
__Deep overbite
__Open bite (front teeth don't overlap)
__Underbite (protruding lower jaw)
__Crossbite
__Cleft lip and / or palate
__Tongue thrust (abnormal swallow)
__Thumb or finger sucking
__Nail biting
__Speech problems
__Other .....
__Difficulties in opening wide, __chewing, or __swallowing
__Clicking noises or pain when opening or closing mouth
__Major fall, accident or operation affecting the teeth or mouth
(explain):.....
.....
__History of major illness. Explain:.....

How often does patient brush his / her teeth? .....

	Yes	No	
a)	◯	◯	Has patient had a previous orthodontic examination?
b)	◯	◯	Does anyone in the family have orthodontic problems?
c)	◯	◯	Has anyone in the family had orthodontic treatment?
d)	◯	◯	Is the patient receptive to having orthodontic treatment?
e)	◯	◯	Does the patient have regular dental care?
f)	◯	◯	Has the patient had any teeth removed?
g)	◯	◯	Does the patient play any musical instruments?
h)	◯	◯	Does the patient wear anything removable in the mouth?
i)	◯	◯	Has the patient reached puberty yet?
j)	◯	◯	Women: are you pregnant? Due date: .....

Please elaborate on any replies below.

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Information may be exchanged between dental offices and insurance companies in order to provide you with the best possible dental care.

SIGNATURE (legal guardian if patient is under 18)

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Relationship to patient (if patient is under 18) .....

Payment is due as treatment is rendered unless prior arrangements are made.