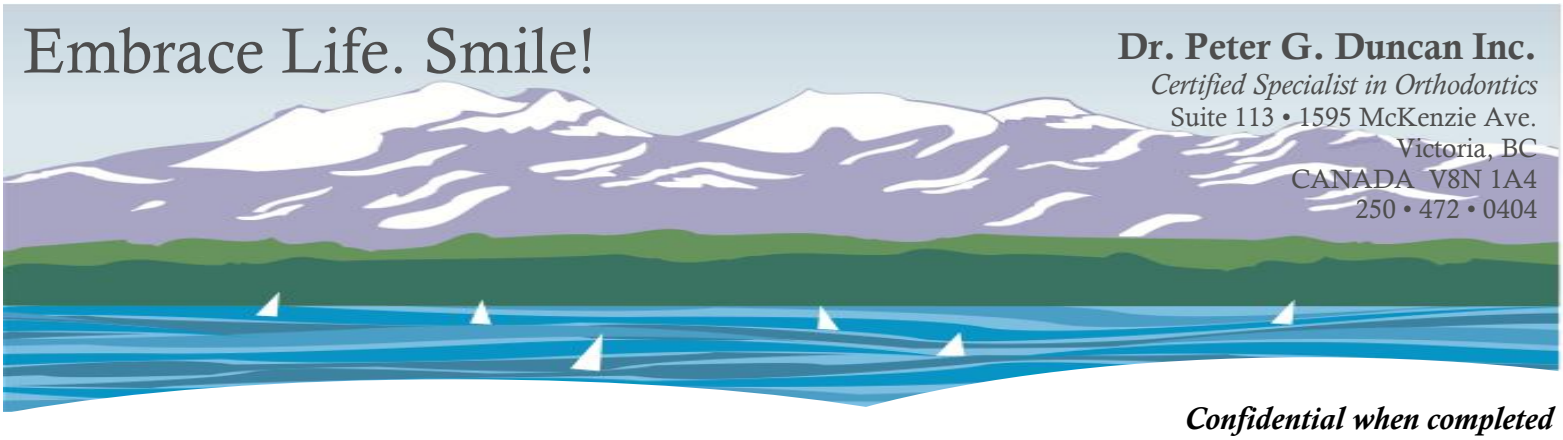
# Embrace Life. Smile!



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***Confidential when completed***

**PATIENT NAME** ☐ Male ☐ Female

Date of Birth (day, month, year)

Address City Postal Code

E-mail Home phone Work phone Cell phone

Dentist Physician

Referred by ☐ Family/Friend ☐ Dentist ☐ Web page/Internet

Is the patient covered by orthodontic insurance? ☐ YES ☐ NO

If yes, please list plan holder's name(s)

Names & Ages of patient's siblings

Kindly complete the *first column* indicating who the patient lives with (who is responsible for the patient's daily activities, appointments, etc.). In the *second column* indicate the person responsible for payment of fees.

| | Who patient lives with: | Financially responsible person: |
|---|---|---|
| Name | | |
| Relationship to patient | | |
| Address (if different from patient) | | |
| E-mail address | | |
| Home Phone | | |
| Social Insurance # | | |
| Occupation/Employer | | |
| Work Phone | | |

**MEDICAL HISTORY**

Is the patient generally healthy? ☐ YES ☐ NO

*Check if the patient has been treated for any of the following conditions:*

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Tuberculosis | ☐ Pneumonia | ☐ Anemia |
| ☐ Prolonged bleeding | ☐ Heart problems | ☐ Bone problems | ☐ Rheumatic fever |
| ☐ Asthma | ☐ Endocrine problems | ☐ Kidney problems | ☐ Nervous problems |
| ☐ AIDS | ☐ Epilepsy | ☐ Liver problems | ☐ Fainting or dizziness |

Does the patient require antibiotics *prior* to any dental work? ☐ YES ☐ NO

Is the patient taking any drugs and/or medications? ☐ YES ☐ NO

Is the patient allergic to any drugs and/or medications? ☐ YES ☐ NO

**DENTAL HISTORY**

Does the patient have any missing OR extra permanent teeth? ☐ YES ☐ NO

Has the patient ever injured their face, mouth or teeth? ☐ YES ☐ NO

Does the patient have any difficulty chewing foods? ☐ YES ☐ NO

Does the patient have any speech problems? ☐ YES ☐ NO

Was the patient's last dental checkup *within* the last 6 months? ☐ YES ☐ NO

Does the patient have dental treatment pending? ☐ YES ☐ NO

Does the patient have other family members in orthodontic treatment? ☐ YES ☐ NO

Who initiated this appointment? ☐ Patient ☐ Dentist ☐ Other ☐