NORTH CALGARY ORTHODONTICS

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Your oral health and safety are our priorities. The following information enables us to provide you with the best orthodontic care, safely and effectively. Please complete the entire form. During your visit, you will be asked questions regarding your questionnaire responses. All information is confidential and treated in accordance with applicable provincial and federal privacy legislation.

Collection, Use and Disclosure of Personal Information: Your information at North Calgary Orthodontics is protected under provincial and federal legislation. We will use your health information only to support the health services we provide such as; providing your treatment and care, verifying your eligibility for health services, to conduct investigations or reviews of the practice, support health provider education, or for internal management purposes. We will not disclose your health information to non-health care agencies without your consent, except in special family or emergency circumstances. You will be asked for your consent before we give your information to anyone other than another health agency involved in your care. For more information about our privacy and information security policies, you may speak to our Privacy Officer in person or by calling our office.

Patient Information (adult form)

Name: (Last)	First	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Preferred first name:	Gender: ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):	

Address: (Street)	Apt/Suite	City	Province	Postal Code

Phone: (Home)	Cell	Work

Other family members treated here:

Email Address:

General Dentist's Name:	Physician's Name:

Emergency Contact: (Name)	Phone	Relationship to patient

Whom may we thank for referring this patient to our office?

Insurance Information

Name of **Primary** Insurance Company:	Employer:	Group/Policy #
Name of Policy Holder:	Policy Holder Date of Birth (MM/DD/YYYY):	ID/Cert. #

Name of **Second** Insurance Company:	Employer:	Group/Policy #
Name of Policy Holder:	Policy Holder Date of Birth (MM/DD/YYYY):	ID/Cert. #

Dental History

	Yes	No	*If yes, please explain:*
Has the patient suffered any trauma to teeth/head/face?	☐	☐	
Is there a history of thumb/finger sucking or mouth habits?	☐	☐	
Has the patient consulted an orthodontist previously?	☐	☐	
Has the patient had any previous orthodontic treatment?	☐	☐	
Has the patient ever had a bad dental experience?	☐	☐	
Does the patient have any discomfort with their current bite?	☐	☐	
Does the patient have any speech problems?	☐	☐	

Have you had any of the following:	Yes	No		Yes	No
History of jaw joint problems (TMJ)	☐	☐	Ringing in the ears	☐	☐
Clenching/grinding teeth	☐	☐	Jaw joint soreness/pain	☐	☐
Muscle soreness of head/neck/jaw joint	☐	☐	Jaw joint clicking/popping	☐	☐
Difficulty opening mouth	☐	☐	Jaw joint locking (open/closed)	☐	☐

Medical History

	Yes	No	
Are you in good health?	☐	☐	If no, explain:
Are you currently taking any medications?	☐	☐	List:
Do you have any allergies (food/medication/latex/penicillin/metal etc.)?	☐	☐	List:
Do you bruise easily or bleed profusely?	☐	☐	If yes, explain:
Have you ever been hospitalized?	☐	☐	If yes, explain:
Have you ever taken bisphosphonates?	☐	☐	If yes, when/how much/for what?
Female: Are you pregnant?	☐	☐	If yes, how many weeks:

Have you had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV+	☐	☐	Epilepsy/seizures	☐	☐	Kidney problems	☐	☐
Anemia	☐	☐	Emotional disturbance	☐	☐	Mitral valve prolapse	☐	☐
Angina	☐	☐	Eye disease	☐	☐	Mouth breathing	☐	☐
Arthritis	☐	☐	Fainting	☐	☐	Nervous disorder/anxiety	☐	☐
Artificial heart valves	☐	☐	Frequent colds/flu	☐	☐	Pneumonia	☐	☐
Artificial joints	☐	☐	Frequent cold sores	☐	☐	Rheumatic fever	☐	☐
Asthma	☐	☐	Frequent cough, skin rash, diarrhea	☐	☐	Sinus trouble	☐	☐
Bone/Blood disorders	☐	☐	Growth disorder	☐	☐	Stomach problems	☐	☐
Blood pressure (high/low)	☐	☐	Gland problems	☐	☐	Stroke	☐	☐
Cancer/tumor	☐	☐	Heart murmur/Heart surgery	☐	☐	Thyroid disease	☐	☐
Congenital heart defects	☐	☐	Heart disease	☐	☐	Tonsilitis	☐	☐
Diabetes	☐	☐	Hepatitis/Liver problems	☐	☐	Tonsil removed | Age:	☐	☐
Depression	☐	☐	Herpes	☐	☐	Tuberculosis	☐	☐
Endocrine problems	☐	☐	Hypoglycemia	☐	☐	Ulcers	☐	☐

Additional Information

What are your reason(s) for seeking orthodontic consultation?

Authorization

☐ To the best of my knowledge, the above is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Date:	Signature:

Patient Consent

I, _____ , consent to the collection, use and disclosure of my personal, dental, and health information for the purpose of providing treatment and care. I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting or not consenting to its release.

I understand that I may revoke my consent at any time, by providing a signed, written statement to North Calgary Orthodontics. This consent to release information will remain in effect until such time notification is received.

Patient Name (PLEASE PRINT):	Witness:
Patient Signature:	Date: