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 (child form)

Name: Last	First	Middle Initial	Age
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?			

If patient is a minor, please fill the information below:

Mother's Information:	Name	Home phone	Cell	Work phone
Father's Information:	Name	Home phone	Cell	Work phone
Guardian's Information:	Name	Home phone	Cell	Work phone

Additional Information

Height (ft):	Weight (lbs):	School Name:	Grade:
Hobbies:		Musical Instrument(s):	
Reason(s) for seeking orthodontic consultation?			
Is there anything special about your child that you would like to share with us?			

Financial Information

Who is responsible for the patient's account? ☐ Patient ☐ Mother ☐ Father ☐ Guardian ☐ Other				If Other, specify:
Address: Street	Apt/Suite	City	Province	Postal Code
Do you have insurance? ☐ Yes ☐ No		Do you have more than one insurance carrier? ☐ Yes ☐ No		
Do you know what your orthodontic coverage is?				

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?	☐	☐	

Please check if the patient has 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	
Is your child in good health?	☐	☐	If no, explain:
Is your child currently taking any medications?	☐	☐	List:
Does your child have any allergies (food/medication/latex/penicillin/metal etc.)?	☐	☐	List:
Does your child bruise easily or bleed profusely?	☐	☐	If yes, explain:
Has your child ever been hospitalized?	☐	☐	If yes, explain:
Has your child ever taken bisphosphonates?	☐	☐	If yes, when/how much/for what?
Female: Is the patient pregnant?	☐	☐	If yes, how many weeks?

Has your child had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV+	☐	☐	Emotional disturbance	☐	☐	Pneumonia	☐	☐
Anemia	☐	☐	Fainting	☐	☐	Rheumatic fever	☐	☐
Asthma	☐	☐	Frequent colds/flu	☐	☐	Sinus trouble	☐	☐
Autism or autism spectrum	☐	☐	Frequent cold sores	☐	☐	Stomach problems	☐	☐
Bone/Blood disorders	☐	☐	Frequent headaches	☐	☐	Thyroid disease	☐	☐
Frequent cough, skin rash, diarrhea	☐	☐	Growth disorder	☐	☐	Tonsilitis	☐	☐
Cancer/tumor	☐	☐	Heart Problems	☐	☐	Tonsil removed | Age:	☐	☐
Congenital heart defects	☐	☐	Hepatitis/Liver problems	☐	☐	Other:		
Diabetes	☐	☐	Kidney problems	☐	☐			
Epilepsy/seizures	☐	☐	Mouth breathing	☐	☐			

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 child's health while he/she is under orthodontic treatment.	☐ I am the parent/guardian of _____ I do hereby request and authorize the staff/doctor to perform necessary dental services for the child named above, including but not limited to x-rays, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.
Date:	Signature of Parent/Legal Guardian:

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:
Signature of Parent/Legal Guardian:	Date: