WELCOME TO OUR OFFICE

Patient Information

Patient's First Name _____ Last Name_____

Birth Date (YYYY/MM/DD) _____ Sex ☐ M ☐ F

Home Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

E-mail address _____

How did you hear about us? ☐ Dentist _____ ☐ Internet

☐ Friend/Relative _____ ☐ Other _____

Responsible Party *(please complete the following if patient is under 18)*

First Name _____ Last Name_____

Relationship to Patient _____ Birth Date (YYYY/MM/DD) _____

Address *(if different from patient)* _____

City _____ Province _____ Postal Code _____

Cell Phone _____ Work Phone _____

E-mail address _____

Insurance Information

Relationship of Insured to Patient ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other _____

Insured First Name _____ Last Name _____

Primary Insurance Company _____ Plan/Policy # _____

Subscriber/Certificate # _____ Date of Birth (YYYY/MM/DD) _____

Address _____ City _____ Province ____ Postal Code _____
(if different from patient)

Relationship of Insured to Patient ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other _____

Insured First Name _____ Last Name _____

Secondary Insurance Company _____ Plan/Policy # _____

Subscriber/Certificate # _____ Date of Birth (YYYY/MM/DD) _____

Address _____ City _____ Province ____ Postal Code _____

MEDICAL INFORMATION

Physician's name _____

Have you ever had OR currently have any of the following?

Heart Murmur	Y N
Heart Disease	Y N
Rheumatic Fever	Y N
High Blood Pressure	Y N
Allergies	Y N
Birth defects	Y N
Past operations and/or hospitalization	Y N
Past facial trauma	Y N
Past or current bleeding disorders	Y N
HIV/AIDS	Y N
Hepatitis	Y N
Cancer/Chemotherapy	Y N
Tonsils or adenoids removed	Y N
Currently under physician's care	Y N
Emotional/psychological problems	Y N
Bone Disorders	Y N
Recent growth spurt	Y N
Latex Allergy	Y N
Other medical problems	Y N

Please explain all "yes" answers: _____

_____

Are you currently taking any Medication(s)? Y N

If Yes, please list all Medications:_____

_____

Do you have any allergies to medications? Y N

If Yes, please list all medications: _____

_____

Do you require Antibiotics before any dental procedures? Y N

If Yes, please explain: _____

_____

DO YOU SMOKE? Y N

Females

Has menstruation begun?	Y N
Are you Pregnant?	Y N
Are you taking birth control pills?	Y N

DENTAL INFORMATION

Dentist's name _____

How long have you been going to the above dentist? ____ Yrs

How often do you go to your dentist?
☐ Regular Checkups ☐ Infrequently ☐ Emergencies Only

When was your last dental appointment? _____

Have you ever had OR currently have any of the following?

Trauma to your teeth	Y N
Thumb or finger sucking	Y N
Clicking of jaw	Y N
Frequent headaches	Y N
Tooth grinding or clenching	Y N
Mouth breathing	Y N
Tongue thrust/habit	Y N
Difficulty in chewing	Y N
Pain in Jaws	Y N
Speech problem	Y N
Breathing problems	Y N
Extraction of teeth	Y N
Other jaw problems	Y N

Please explain all "yes" answers: _____

_____

Why are you seeking Orthodontic Treatment?

_____

Have you consulted another orthodontist? Y N

If Yes, How long ago?_____

Have you had previous Orthodontic Treatment? Y N

If Yes, How long ago? _____

Has anyone else in the family had orthodontic treatment? Y N

If Yes, Please Explain:_____

I hereby give Dr. Arun Rajasekaran and his staff permission to release information regarding my child's dental and orthodontic health to other health professionals as is deemed necessary.

Parent/Patient signature_____ **Date**_____