WELCOME TO OUR OFFICE

LIBERTY ORTHODONTIC CENTRE

Patient Information

Patient's First Name _____ Last Name_____

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

Home Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

E-mail address _____ **CONFIRMATION BY:** ☐ E-mail **OR** ☐ Text/SMS

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 _____ E-mail address _____

WHO DOES THE PATIENT LIVE WITH? ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Insurance Information

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

Insured First Name _____ Last Name _____

Primary Insurance Company _____ Date of Birth (YYYY/MM/DD) _____

Plan/Policy # _____ Certificate/ID # _____

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 _____ Date of Birth (YYYY/MM/DD) _____

Plan/Policy # _____ Certificate/ID # _____

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

*****PLEASE TURN OVER AND FILL OUT THE INFORMATION ON THE BACK*****

MEDICAL INFORMATION

Physician's Name: _____

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

	Yes	No
Heart Murmur	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐
Allergies	☐	☐
HIV/AIDS	☐	☐
Hepatitis	☐	☐
Emotional/psychological problems	☐	☐
Other medical problems	☐	☐

Please explain all "yes" answers: _____

_____

_____

Are you currently taking any Medication(s)?

Please list all: _____

_____

Do you have any allergies to medications?

Please list all: _____

_____

Do you require Antibiotics before any dental procedures?

Please explain: _____

_____

DO YOU SMOKE? ☐ **YES** ☐ **NO**

DENTAL INFORMATION

Dentist's Name: _____

How long have you been going to the above dentist? _____ Years

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?

	Yes	No
Trauma to your teeth	☐	☐
Thumb or finger sucking	☐	☐
Clicking of jaw	☐	☐
Tooth grinding or clenching	☐	☐
Mouth breathing	☐	☐
Tongue thrust/habit	☐	☐
Pain in Jaws	☐	☐
Breathing problems	☐	☐

Please explain all "yes" answers: _____

_____

Why are you seeking Orthodontic Treatment?

_____

Have you consulted another orthodontist?

How long ago? _____

Have you had previous Orthodontic Treatment?

How long ago? _____

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

Parent/Patient signature _____ **Date** _____