Patient Information

Patient Name _____ Male○ Female○ Birth date_____

Name of Parent or Guardian (if applicable): Mother _____ Father _____

Please Indicate Parents' Relationship Status: Married _____ Separated _____

Address _____ City _____ Postal Code _____

Telephone: Home_____ Business (M)_____ (F) _____ Cell _____

Physician _____ Telephone _____ Dentist _____ Telephone _____

Dental Insurance Co. #1_____ Dental Insurance Co. #2_____

Subscriber: _____D.O.B.: _____ Subscriber: _____ D.O.B.: _____

Policy/Group #: _____ I.D. #: _____ Policy/Group #: _____ I.D. #: _____

Medical History

		YES	NO
1.	Do you consider yourself to be in good health?	○	○
2.	Are you presently under the care of a physician?	○	○
3.	Are you presently taking any medicines or drugs? If Yes, please specify _____	○	○
4.	Have you ever been hospitalized, or had a serious illness?	○	○
5.	Do you bleed abnormally?	○	○
6.	Do you bruise easily?	○	○
7.	Do you heal easily and normally?	○	○
8.	Do you suffer from frequent headaches?	○	○
9.	Do you have any ear problems?	○	○
10.	Do you have frequent sinus trouble or nasal congestion?	○	○
11.	Do you get frequent colds or sore throats?	○	○
12.	*FEMALES ONLY*: Are you taking birth control pills?	○	○
	Are you pregnant?	○	○
	If yes, at what stage of pregnancy? _____		
13.	Do you have any allergies?	○	○

If yes, please specify:

○ aspirin ○ local anaesthetics
○ foods ○ penicillin
○ other_____

14. A) Have you ever had, or been treated for any of the following:

○ heart trouble	○ tuberculosis	○ anemia/blood disease	○ cancer
○ HIV/AIDS	○ rheumatic fever	○ mononucleosis	○ growth or tumour
○ heart murmur	○ blood transfusion	○ persistent cough	○ thyroid disease
○ diabetes	○ epilepsy	○ abnormal blood pressure	○ IV drug use
○ asthma	○ mental disease	○ arthritis	○ hepatitis
○ sexually transmitted disease		○ persistent diarrhea	○ persistent skin rash

B) If you have any disease, problem, or condition not listed above, please specify:

Next page, please ☞

Dental History

	YES	NO
1. Do you consider yourself to be in good dental health?	○	○
2. Are you nervous about going to the dentist?	○	○
3. Have you ever had a bad dental experience?	○	○

If so, please describe: _____

4. Have you ever had an injury to your face or jaws? ○ ○

If so, please describe: _____

5. Date of last dental exam: _____ X-rays taken? ○ Yes ○ No ○ Not sure
6. Conditions currently being treated by your dentist: _____
7. How frequently do you brush your teeth? _____
8. How frequently do you floss your teeth? _____
9. What is your reason for seeking orthodontic treatment? _____
10. Have you received any past orthodontic treatment? ○ Yes ○ No ○ Not sure

If yes, please describe: _____

11. Were you referred to our office? ○ Yes ○ No

If yes, by whom? _____

If no, how did you hear about our office? _____

12. **OFFICE USE ONLY** Referral information _____

pan/radiograph ○ Yes ○ No If yes, date of pan _____ date of return _____

Patient/Parental Consent

I, _____ (patient/parent or guardian) for _____ do hereby authorize Dr. Darren Tkach to perform an examination to determine the need for possible orthodontic treatment. As the patient is a minor, I hereby sign on his/her behalf as legal guardian. I authorize Dr. Darren Tkach to discuss aspects of the oral health of the aforementioned patient, or other relevant health information with other health care professionals I have seen (e.g. MD, DDS). I hereby confirm that, to the best of my knowledge, the above information is accurate and correct.

_____ _____

Patient / Parent or Guardian Signature Relationship to Patient

_____ _____

Witness Date