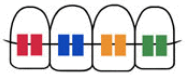
ADULT PATIENT CONFIDENTIAL INFORMATION



Last Name_____First Name_____Initial_____ Mr/Mrs/Miss/Ms/Dr

Consultation Date_____ Date of Birth_____Age_____ Sex_____

Address_____ City_____ Postal Code_____Phone #_____

Referred by _____ Dentist_____ Physician_____

PERSONAL INFORMATION

Person Responsible for account and their address_____
Do you have Orthodontic Insurance?_____
Employed by_____ Occupation_____
Work Phone #_____ Cell Phone # _____May we contact you there?_____
Name of other family members treated_____
Email: _____

MEDICAL HISTORY (Circle Yes or No)

Heart trouble ..... yes .... no
Rheumatic fever..... yes .... no
Hepatitis.....yes .....no
Anaemia.....yes .....no
Headaches.....yes .....no
Eye problems.....yes .....no
Arthritis.....yes .....no

Diabetes..... yes ..... no
Epilepsy..... yes ..... no
Pneumonia.....yes .....no
Prolonged bleeding....yes .....no
Stomach trouble.....yes .....no
Asthma.....yes .....no
Cancer.....yes .....no

AIDS or HIV positive..... yes.....no
Hearing problems..... yes .....no
Ear aches..... yes .....no
Kidney problems..... yes .....no
Fainting & dizziness..... yes .....no
Nervous disorders.....yes .....no

Are you in good health.....yes .....no
List any medications being taken.....
.....
Do you have a tendency to colds.....yes .....no
sore throats.....yes .....no
ear infections...yes .....no

Is there any history of major illness.....yes .....no
List any allergies or drug sensitivities.....
.....
Have tonsils and adenoids been removed.....yes .....no
Do you smoke.....yes .....no
Are you pregnant or anticipating becoming pregnant.....yes.....no

DENTAL HISTORY (Circle Yes or No)

Are you a mouth breather -while awake.....yes .....no
while sleeping .....yes .....no
Are there any missing or extra permanent teeth.....yes .....no
Are you aware of ..... grinding teeth.....yes .....no
jaw joint noise..... yes .....no
pain in ear region.....yes .....no

Any injuries to the face, mouth or teeth.....yes .....no
Do you have any speech problems.....yes.....no
Have any teeth been extracted.....yes .....no
Frequent colds or canker sores.....yes .....no
Previously seen by an orthodontist.....yes.....no
Do you want orthodontic treatment.....yes .....no

Do you play any musical instruments.....yes .....no
When did you last have a dental check-up.....
Do you play sports? Which ones.....
Reason for orthodontic consultation.....

.....
Signature of Patient

.....
Signature of Orthodontist Date