As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. The information you provide below is crucial in allowing us to provide appropriate care for you. Cold Lake & St. Paul Orthodontics does not use this information to discriminate.

* required

PATIENT INFORMATION

First Name* ____________ Last Name* ____________ Gender* ☐ male ☐ female

Preferred Name* ____________ Birthdate* MM / DD / YYYY Age* ____________

Health Number* ____________ School (if patient is a student) ____________

To help our team discuss potential effects of orthodontic treatment on regular activities, please list any sports or hobbies in which the patient is involved, or any musical instruments played. ____________

To help our team assess growth and development for patients under the age of 20, please list all siblings by name including their age, gender, and approximate height. ____________

Does the patient have any friends or family previously/currently seen at Cold Lake & St. Paul Orthodontics?* ☐ yes ☐ no

If yes, who? ____________ How did you hear about Cold Lake & St. Paul Orthodontics ?* ____________

PRIMARY PERSON RESPONSIBLE FOR ACCOUNT AT Cold Lake & St. Paul Orthodontics

Relationship to Patient* ☐ self ☐ mother ☐ father ☐ other ____________

First Name ____________ Last Name ____________ Email ____________

Home Phone ____________ Mobile Phone ____________ Work Phone ____________

Address ____________ City ____________ Postal Code ____________

Employer ____________ Occupation ____________

Preferred correspondence for appointment reminders:* ☐ email ☐ text (to mobile phone)

IF APPLICABLE, SECONDARY PERSON RESPONSIBLE FOR ACCOUNT AT Cold Lake & St. Paul Orthodontics

Relationship to Patient* ☐ spouse ☐ mother ☐ father ☐ other ____________

First Name ____________ Last Name ____________ Email ____________

Home Phone ____________ Mobile Phone ____________ Work Phone ____________

Address ____________ City ____________ Postal Code ____________

Employer ____________ Occupation ____________

DENTAL INFORMATION

Dentist ____________ Office/Location ____________ Date of Last Visit* MM / DD / YYYY

IMPORTANT: What is the primary reason for seeking an orthodontic consultation? (Describe the patient's main concern regarding his/her teeth, smile, or bite.)*

Please be specific. ____________

Does the patient want orthodontic treatment? (please check one)*
☐ yes, patient is excited to begin treatment
☐ patient is not excited but is willing to undergo treatment
☐ patient has little desire to be involved with treatment of any kind

Has the patient had an orthodontic consultation or any orthodontic treatment in the past?* ☐ yes ☐ no

If yes, when and where? ____________

Has the patient ever had any of the following habits? (daily or almost daily)*

☐ sucking thumb, fingers, pacifiers, or objects (beyond the age of 6)
☐ lip or cheek sucking or biting
☐ snoring
☐ chronic mouth breathing
☐ clenching or grinding teeth

Does the patient have difficulty breathing, chewing, swallowing, or speaking? Does the patient experience daily pain or locking with the jaw joint (TMJ)?*

☐ yes ☐ no If yes, please explain. ____________

How often does the patient brush his/her teeth? (please check one)*

☐ once per day ☐ twice per day ☐ three or more times per day ☐ brushing is not a daily habit

How often does the patient floss his/her teeth? (please check one)*

☐ at least once per day ☐ at least once per week ☐ irregularly or not at all

Do any of the following exist? If yes, please explain.* ____________

☐ past major facial/dental traumas ☐ past major dental treatments ☐ planned or unfinished dental treatments

(continued on reverse)

MEDICAL INFORMATION

Doctor ______________________ Office/Location ______________________ Date of Last Visit* MM / DD / YYYY

Is the patient currently under the care of a medical professional for a specific condition?*

☐ yes ☐ no If yes, please explain. ______________________

Is the patient currently taking any prescription medications, over-the-counter medications, vitamins, natural or herbal preparations, or diet supplements?*

☐ yes ☐ no If yes, please list. ______________________

Has the patient experienced significant allergies or adverse reactions to any of the following?*

☐ medications ☐ environment/animals/plants ☐ rubber/plastics/metals ☐ foods

Please specify. ______________________

Has a physician or dentist ever recommended the patient take antibiotics or other medication prior to any dental treatment because of a medical condition?

☐ yes ☐ no ☐ unsure If yes, who made the suggestion and what did they suggest?* ______________________

Has the patient had his/her tonsils or adenoids removed?* ☐ yes ☐ no

FOR FEMALE PATIENTS ONLY: Is the patient pregnant? ☐ yes ☐ no ☐ unsure If yes, what is the due date? MM / DD / YYYY

Does the patient have, or has the patient had, any of the following: (Please check all that apply)*

☐ abnormal bleeding / haemophilia
☐ acid reflux / persistent heartburn
☐ AIDS / HIV
☐ alcohol or drug abuse
☐ arthritis / osteopenia / osteoporosis
☐ asthma / bronchitis / COPD
☐ autism / Asperger syndrome
☐ cancer / chemotherapy / radiation
☐ cleft lip / cleft palate
☐ colitis / Crohn's / celiac disease
☐ diabetes (type I or type II)
☐ eating disorder
☐ emotional, behavioural or mental health problems (e.g. depression, anxiety, etc.)
☐ epilepsy / seizures
☐ frequent headaches / migraines
☐ hay fever
☐ heart failure / angina / pacemaker
☐ heart murmur / heart valve disease
☐ fainting spells
☐ high or low blood pressure
☐ kidney problems
☐ learning disability
☐ liver disease (e.g. hepatitis)
☐ sinus problems (e.g. sinusitis)
☐ skin problems
☐ sleep apnea
☐ smoking / chewing tobacco
☐ stroke
☐ thyroid problems

If the patient has ever had or currently has any of the above, please provide details on treatment received and current status.

____

Describe any other medical condition, disease, or problem not listed that the patient has had, or is currently being treated for.

____

COMPLETION DETAILS

NOTE: Both the doctor and the patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that the orthodontist and his/her staff will rely on this information for providing treatment. I will not hold the orthodontist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Consent for Records: I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examination, treatment, or retention, for purposes of professional consultation, third-party appliance manufacturing, research, marketing, and education. I give my full permission to use any photos/video taken of myself inside the Cold Lake and St.Paul Orthodontics office for use on social media platforms for contests, office news and any other promotional uses.

Name of Person Who Completed This Form:* ______________________

Relationship to Patient* ☐ self ☐ mother ☐ father ☐ other ______________________

Date:* MM / DD / YYYY Signature: ______________________

Our office software may disclose your information to third party organizations to perform activities such as processing and storage of your information. Some of these organizations may use facilities and resources located outside of Canada and accordingly your personal information may be collected, used, disclosed, stored, processed, and destroyed outside of Canada for the purposes described. As a result, your personal information may be subjected to the laws of foreign jurisdictions (including those of the United States of America) and may be available to foreign governments or their agencies under a lawful order or through other judicial processes.