Richmond Hill Orthodontics

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Welcome To Our Office!

Please Complete All Information On Both Sides

Patient Information

Patient's Last Name:_____ First Name:_____ Preferred Name:_____

Sex : M / F Age:_____ Birth Date (MM/DD/YYYY):_____ S.I.N. _____

Home Address: _____ City & Province:_____ Postal Code:_____

Home Phone: ( )_____ Cell Phone: ( )_____ E-mail:_____

Emergency Contact: _____ Relation: _____ Phone: ( )_____

How Did You Hear About Us? Referred By: ☐Your Dentist ☐Friend / Relative ☐Sign ☐T.V. Commercial ☐Web Site

Children In Family (Name & Age) _____

Does Any Relative Have A Similar Bite? Y / N Who?_____ Friends/Relatives Treated Here? _____

Mother's Information

Name: _____S.I.N._____

Birth Date (MM/DD/YYYY): _____

Hm #: ( )_____Cell #: ( )_____

Wk #: ( )_____ E-mail:_____

Employer: _____Occupation: _____

Father's Information

Name: _____S.I.N._____

Birth Date (MM/DD/YYYY): _____

Hm #: ( )_____ Cell #: ( )_____

Wk #: ( )_____ E-mail:_____

Employer: _____Occupation: _____

Financial Information

Responsible Party For the Financial Account: ☐Mom ☐Dad ☐Guardian Name:_____ ☐Other: _____

Address: _____ City & Province: _____ Postal Code:_____

Phone: ( )_____ Birth Date (MM/DD/YYYY):_____ S.I.N._____

Do You Have Dental Insurance? Y / N **Does it Cover Orthodontics? Y / N / Uncertain** **Do You Have Dual Coverage? Y / N**

Primary Dental Insurance Information

Insur. Carrier: _____Tel: ( )_____

Address: _____

Insured Name: _____ Rel to Patient: _____

S.I.N._____ Birth Date: _____

Policy #: _____ Cert #: _____ Div #: ____

Employer: _____ Max. Coverage: $_____

Secondary Dental Insurance Information

Insur. Carrier: _____Tel: ( )_____

Address: _____

Insured Name: _____ Rel to Patient: _____

S.I.N._____ Birth Date: _____

Policy #: _____ Cert #: _____ Div #: ____

Employer: _____ Max. Coverage: $_____

Medical History

Are You in Good Health? Y / N Reason:_____ Name of Physician: Dr._____

Are You Currently Under a Physician's Care? Y / N For What?_____

Physician's Address: _____ City & Province: _____ Postal Code:_____

Phone Number: ( )_____ Date of Last Medical Visit (MM/DD/YYYY): _____

Are You Currently Taking **ANY** Medication(s)? Y / N List Name(s) & Reason): _____

Do You Have **ANY** Allergies? Y / N What? ☐Penicillin ☐Amoxicillin ☐Aspirin ☐Codeine ☐Erythromycin ☐Food/Drinks ☐Dental Anesthetics ☐Metals ☐Nickel ☐Latex ☐Plastic ☐Other: _____

Are You Required To Take Antibiotics Prior To General Dental Procedures? Y / N Explain: _____

FEMALE ONLY: Has Menstruation Started? Y / N Are You Pregnant? Y / N Are You Taking Birth Control Pills? Y / N

Have You Ever Had OR Currently Have (Please Circle):

Y / N Heart Disease	Y / N Kidney Disease	Y / N Nasal Blockage	Y / N Emotional Problem(s)
Y / N Rheumatic Fever	Y / N Diabetes	Y / N Drug / Alcohol Use	Y / N Psychiatric Therapy
Y / N Heart Murmur	Y / N Seizures / Epilepsy	Y / N Hepatitis / Jaundice	Y / N Digestive Disorder
Y / N High Blood Pressure	Y / N Asthma	Y / N Tuberculosis	Y / N Hospitalization
Y / N AIDS / HIV+	Y / N Arthritis	Y / N Thyroid Disease	Y / N Bleeding Disorder
Y / N Heart Surgery	Y / N Artificial Bones / Joints	Y / N Frequent Colds or Flu	Y / N Childhood Disease
Y / N Artificial Valves	Y / N Cancer / Chemotherapy	Y / N Major Illnesses	Y / N Birth Defect

If You Answer **YES** to Any of the above, Please Explain: _____

Any Other Information Which May Be of Value in Treatment? _____

Dental History

Name of Family Dentist: Dr._____ Dental Office Name: _____

Dentist's Address: _____ City & Province: _____ Postal Code:_____

Phone Number: ( )_____ Date of Last Dental Visit (MM/DD/YYYY): _____

Why are You Seeking Orthodontic Treatment? ☐Cosmetics ☐Bite ☐Function ☐Dentist Referral ☐Other: _____

Please Describe Your Main Concern / Chief Complaint / Goal: _____

Have You Consulted an Orthodontist Previously? Y / N If Yes, How Long Ago? _____

Have You Had Any Previous Orthodontic Treatment? Y / N How Long Ago / Outcome? _____

Have You Ever Had OR Currently Have (Please Circle):

Y / N Clicking in Jaw Joints	Y / N Cold or Canker Sores	Y / N Breathing Problem(s)	Y / N Injuries to the Teeth
Y / N Noises in Jaw Joints	Y / N Suck Thumb / Finger	Y / N Speech Problem(s)	Y / N Injuries to the Face
Y / N Pain in Jaw Joints	Y / N Tongue Thrust / Habit	Y / N Extra Teeth	Y / N Difficulty Chewing
Y / N Pain in Ears or Cheeks	Y / N Bite Pens / Lips / Nails	Y / N Missing Teeth	Y / N Difficulty Opening
Y / N Frequent Headaches	Y / N Grind / Clench Teeth	Y / N Extraction(s) of Teeth	Y / N Tonsils Removed
Y / N Mouth Breathing	Y / N Play Instrument(s): What? _____	Y / N Gum Problem(s)	Y / N Adenoids Removed

If You Answered **YES** to Any of the Above, Please Explain: _____

Any Other Information Which May Be of Value in Treatment? _____

Thank you for being a part of our orthodontic community – please inform us if you would like to schedule a consultation for any member of your family and/or friends! I hereby certify that I have read & completed this form to the best of my knowledge, and all the preceding answers are true & correct.

Parent / Guardian Signature: _____ Date (MM/DD/YYYY): _____