WINNIPEG ORTHODONTIC GROUP

Welcome to Our Office!

Please take a few minutes to complete the following form to help us better understand your orthodontic needs. All information you provide is confidential.

Date:_____

Patient's Name:_____ Gender: ❑ Male ❑ Female
Given Name(s) Surname

Address:_____
No. Street City/Town Postal Code

Home Phone #:_____ Cell Ph#:_____ Work Ph#:_____

Date of Birth:_____/_____/_____ Age:_____ Email:_____
Day Month Year

Who is financially responsible for this account? Relationship to you: _____

Name:_____

Address:_____
No. Street City/Town Postal Code

Home Phone #: _____ Work Phone #:_____

Do you have a dental plan that covers orthodontic treatment? ❑ Yes ❑ No

Employer: _____

Name of insurance company:_____

Policy #:_____ ID #:_____

A dental insurance plan is a contract between you and your insurance company. It is the policy of this office to bill and receive payment directly from our patients for services rendered. We will gladly assist you in preparing claims to submit to your insurance company for reimbursement.

How did you select our office?

❑ Referral from family/friend ❑ Referral from dentist ❑ Location ❑ Internet ❑ Other_____

Reason for seeking an orthodontic consultation:_____

Do you have any concerns about how the teeth look? ❑ Yes ❑ No

If yes, how would you like them changed?_____

_____

Do you have any concerns about the bite of the teeth? ❑ Yes ❑ No

If yes, please tell us what you see as the problem?_____

_____

Do you have any concerns about the facial appearance/profile? ❑ Yes ❑ No

If yes, what would you like to be different?_____

_____

Any other concerns?_____

Medical Information: Physician's Name:_____

Date of last exam:_____

Please indicate if any of the following now or in the past applies to you:

- ❑ Congenital/hereditary conditions
- ❑ Operations &/or hospitalization
- ❑ Past facial trauma or bone fracture
- ❑ Anemia
- ❑ Bleeding disorders
- ❑ Heart or cardiovascular problems
- ❑ Rheumatic fever
- ❑ Arthritis or rheumatism
- ❑ Cigarette smoking or tobacco chewing (Packs/day:)
- ❑ Diabetes or kidney problems
- ❑ Stomach problems
- ❑ Neurological problems
- ❑ Liver problems or Hepatitis
- ❑ HIV/AIDS
- ❑ Bone disorders
- ❑ Thyroid problems
- ❑ Allergies
- ❑ Cold sores/Herpes
- ❑ Tonsils or adenoids removed
- ❑ Hayfever, asthma
- ❑ Ear problems
- ❑ Eye problems
- ❑ Emotional/psychological problems
- ❑ Currently under physician's care
- ❑ Currently taking medications
- ❑ Bisphosphonates taken in the past
- ❑ Other medical conditions (indicate below)

If you indicated any of the above, please explain:_____

_____

_____

Dental Information: Dentist's Name:_____

Date of last dental appointment:_____

How often do you visit the dentist? ❑ Regular check-ups ❑ Infrequently ❑ Only for emergencies ❑ Never

How many times do you brush? _____ Floss? _____

Has anyone else in the family had orthodontic treatment? ❑ Yes ❑ No
If yes, was treatment for a similar problem? ❑ Yes ❑ No Was treatment successful? ❑ Yes ❑ No

Have you now or in the past had any of the following?

Past	Current		Past	Current	
❑	❑	Previous orthodontic treatment or consultation	❑	❑	Gum (periodontal) disease
❑	❑	Seen a root canal, oral surgery or gum specialist (Please circle which one.)	❑	❑	Speech problem
			❑	❑	Difficulty chewing, swallowing, eating
❑	❑	Problems associated with previous dental or orthodontic treatment	❑	❑	Thumb or finger sucking or other habits
			❑	❑	Problems breathing through the nose
❑	❑	Tooth grinding or clenching	❑	❑	Dental or facial pain
❑	❑	Fractured teeth or trauma to any teeth or jaws	❑	❑	Jaw joint (TMJ) pain, clicking noises or locking
❑	❑	Extracted teeth (baby teeth or permanent)	❑	❑	Frequent headaches
❑	❑	Extra (supernumery) or missing teeth	❑	❑	Other dental problems (indicate below)

If you indicated any of the above, please explain:_____

_____

_____

By providing my email address I agree to accept electronic communication from the doctors and staff at the Winnipeg Orthodontic Group.

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for errors or omissions that I have made in completion of this form. If there are any changes later to this history record or medical/dental status, I will inform the practice.

Patient Signature: _____ ***Date:***_____