Acquaintance Form

STO ORTHODONTISTS

Creating a world of smiles for over 25 years!

PLEASE TELL US WHY YOU ARE SEEKING AN ORTHODONTIC CONSULTATION:

_____

PATIENT INFORMATION

Patient Name (First / Last)

Gender ❍ M ❍ F ❍ NB | Age | Date of birth (Day/Month/Year)

Address | Apt | City | Postal code

Home Phone | Cell | Email

Name of Dentist | Who referred you to our office?

Emergency contact name / Relationship to patient / Contact number

PARENT / GUARDIAN INFORMATION (IF APPLICABLE)

Parent's Name (First / Last) | Contact Number

Address | Apt | City | Postal code | Email

Parent's Name (First / Last) | Contact Number

Address | Apt | City | Postal code | Email

Who will be accompanying the patient for the appointment?

Do you have an insurance plan that covers orthodontic treatment?
❍ Y ❍ N

MEDICAL INFORMATION :

Name of family doctor and contact number: _____

Heart Disease	❍ Y ❍ N	Cancer	❍ Y ❍ N	Sleep Apnea	❍ Y ❍ N	Tuberculosis	❍ Y ❍ N	Liver Disease	❍ Y ❍ N
Infective Endocarditis	❍ Y ❍ N	Diabetes	❍ Y ❍ N	Asthma	❍ Y ❍ N	Hepatitis A, B or C	❍ Y ❍ N	Autism	❍ Y ❍ N
Heart Defect / Repair	❍ Y ❍ N	Blood Disease	❍ Y ❍ N	Arthritis	❍ Y ❍ N	H.I.V / A.I.D.S	❍ Y ❍ N	Prolonged Bleeding	❍ Y ❍ N

If response is YES to any of the above, please give details:_____

Other medical conditions (not listed above):_____

Is antibiotic medication required for dental cleanings? ❍ Yes ❍ No

List any allergies and drug sensitivities:

A: Medications B: Latex C: Metal/Nickel D: Other (eg: foods/hayfever)

_____

List any medication(s) now being taken and please give reasons:

_____

Have tonsils and/or adenoids been removed?

_____ What Age: _____

Are there any mental health concerns?

_____

(Women) Are you pregnant?

❍ Yes ❍ No

Have you ever taken medications for osteoporosis? ❍ Yes ❍ No

DENTAL INFORMATION :

Has there ever been treatment for a jaw joint problem, including surgery?
❍ Yes ❍No

Have there been any injuries to the face, mouth or teeth?
❍ Yes ❍ No

Any thumb or finger habit? If yes, until what age?
❍ Yes ❍ No Stopped at Age____

Any speech problems?
❍ Yes ❍ No

Frequent canker or cold sores?
❍Yes ❍ No

Do gums bleed when brushing or flossing?
❍ Yes ❍ No

Have you ever seen a Periodontist (gum specialist)?
❍ Yes ❍ No

If Yes Dr's name & Date of last visit_____

Are you a mouth breather?
❍ Yes ❍ No

Has there been a previous orthodontic examination?
❍ Yes ❍ No

Have any other family members ever had braces or orthodontic treatment?
❍ Yes ❍ No If yes, have any of them been treated by us?

_____

When was the last visit to the family dentist? _____

RELEASE OF INFORMATION: I hereby give Scarborough Town Orthodontics and/or members of the staff permission to release information concerning my dental and/or orthodontic health to my family physician, dentist or any other dental specialists as is deemed necessary. This information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

Doctor Initials

_____
SIGNATURE DATE