Strasdin Sangha ORTHODONTICS

#202, 11002-104 Ave.
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Phone: 780 538 9969
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1 866 295 9969

Patient Information

To become better acquainted and to be able to offer you the best possible care, we ask that you complete this information form.

Date_____ Patient's Age_____ ☐ Male ☐Female

Patient's Name_____ Birthday_____/_____/_____
Last First M Preferred D M Y

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Employer (Optional)_____

Dentist's Name_____ Family members seen by us_____

Whom may we thank for referring you? ☐ Dentist ☐ Friend ☐ Family Member ☐ Website
☐ Other_____
(please elaborate)

Parent Information (please complete if patient is under the age of 18)

Patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other (please specify)_____

Person responsible for account_____ Relation_____

Address_____ City_____ Prov_____ PC_____
(if different from the patient)

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____

Mother's Information

☐ Stepmother ☐ Guardian

Name_____
Last First Preferred

Address_____
(if different from patient)

City_____ Prov_____ PC_____

Birth date_____

Home Phone_____

Cell Phone_____

Work Phone_____

Email_____

Father's Information

☐ Stepfather ☐ Guardian

Name_____
Last First Preferred

Address_____
(if different from patient)

City_____ Prov_____ PC_____

Birth date_____

Home Phone_____

Cell Phone_____

Work Phone_____

Email_____

Insurance Information

Our office charges the patient/parent/guardian directly for all professional services rendered.

Do you receive funding through: ☐ Indian Affairs ☐ Social Assistance ☐ A.I.S.H. ☐ Ward of Government ☐ Cleft Palate Clinic

Patients Treaty Number:_____

Patients Social Assistance /AISH/Ward of Government Recipient Number: _____

Dental History

Reason for orthodontic consultation (chief concern)_____

Is the patient happy with his/her smile? ☐ Yes ☐ No If not, what would he/she change?_____

Has the patient ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Does the patient want treatment? ☐ Yes ☐ No ☐ Unsure

Has the patient now or ever experienced problems with their jaw joints (TMJ)? ☐ Yes ☐ No

If yes, please specify_____

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

If yes, please specify_____

Has the patient had or presently have any of the following habits? ☐ Thumb/finger sucking ☐ Lip biting ☐ Snoring ☐ Grinding ☐ Clenching ☐ Chronic mouth breathing ☐ Speech problems ☐ Tongue thrusting ☐ Chewing/eating problems ☐ Sinus problems ☐ Nail biting

Does the patient see the dentist regularly? ☐ Yes ☐ No How often does the patient brush?_____

How often does the patient floss?_____

Medical History

Physician's Name_____ Physician's Phone #_____

Patient' s current physical health is ☐ Good ☐ Fair Is the patient currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain_____

Does the patient require antibiotics before dental treatment? ☐ Yes ☐ No If yes, please explain_____

Is the patient taking any prescription or over the counter drugs? ☐ Yes ☐ No List all_____

Does the patient have any allergies? ☐ Yes ☐ No List all_____

Does the patient use tobacco? (smoking or chewing) ☐ Yes ☐ No

For women: Is the patient pregnant? ☐ Yes ☐ No ☐ Unsure For the reasons relating to growth development, has the patient started her menstrual cycle? ☐ Yes ☐ No If yes what age? _____

DOES THE PATIENT HAVE NOW, OR EVER HAD ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
Anemia/Blood Transfusion/Hemophilia	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
AIDS/HIV	☐	☐	Difficulty breathing	☐	☐	Hospitalized for any reason	☐	☐
Alcohol/Drug Abuse	☐	☐	Emotional/Psychiatric problems	☐	☐	Kidney problems	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐
Arthritis	☐	☐	Epilepsy/Seizures/Fainting	☐	☐	Lupus	☐	☐
Artificial joints/bones/valves	☐	☐	Fetal alcohol syndrome	☐	☐	Rheumatic/Scarlet fever	☐	☐
Asthma	☐	☐	Frequent headaches	☐	☐	Shingles	☐	☐
Cancer/Chemotherapy/Radiation treatment	☐	☐	Glaucoma	☐	☐	Sickle cell disease/traits	☐	☐
Colitis/Crohn's	☐	☐	Hay fever	☐	☐	Tuberculosis	☐	☐
Cystic Fibrosis	☐	☐	Hepatitis	☐	☐	Ulcers	☐	☐
Congenital heart defect/Mitral valve prolapse	☐	☐	Herpes	☐	☐			
			Heart murmur	☐	☐			

If yes to any of the above, please explain_____

Describe any other medical condition not listed_____

Office Financial Policy: Because insurance companies vary greatly in the amount of coverage and the method of payment for orthodontic treatment, our arrangements and responsibility for payment are made only with the patient or parent(s).

There will be a 2% Interest per month charged on any account over 90 days past due. The patient or responsible party agrees that in the event they do not remit payment for an outstanding invoice or service this debt is turned over to a collection agency, they will pay an additional collection fee equal to 45% of the outstanding amount. Initials:_____

Person Responsible for the account: Both Parents_____ Father_____ Mother_____ Self_____ Spouse_____ Other_____

Driver's license or SIN of responsible party(s):_____ _____

Signature of responsible party(s): X

Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Parent/Guardian X_____Date_____