PATIENT REGISTRATION FORM

PATIENT'S NAME ___________________________________ DATE OF BIRTH____________________ AGE________SEX:❑ M ❑ F
ADDRESS ____ CITY__________________ POSTAL CODE_______________
HOME PHONE#____________________________________ PHYSICIAN'S NAME ____
DENTIST'S NAME ______________________________ WHO RECOMMENDED YOU TO US? ______________________________
EMAIL ADDRESS__________________________________

PARENT INFORMATION (FOR MINORS)

MOTHER____Cell/Work#__________________________________
FATHER____ Cell/Work#__________________________________
MARITAL STATUS: ❑ Single ❑ Married ❑ Common-Law ❑ Separated ❑ Divorced ❑ Widowed
ADDRESS (If different than above) ____

		Yes	No	Not Sure
1. Is there any history in your family of crooked teeth?	....	❑	❑	❑
2. Have any members of your family received orthodontic treatment?	....	❑	❑	❑
3. Is the orthodontic problem obvious to you?	....	❑	❑	❑
4. Are you becoming self-conscious of your teeth?	....	❑	❑	❑
5. Have you ever sucked your fingers/thumb, if so until what age _________	....			
6. Do you play any wind instruments?	....	❑	❑	❑
7. Have you had any severe accidents involving the teeth, jaws or lips?	....	❑	❑	❑
8. Do you have frequent:				
Sore throats?	....	❑	❑	❑
Asthma?	....	❑	❑	❑
Hayfever or Allergies?	....	❑	❑	❑
9. Do you have any LATEX ALLERGIES?	....	❑	❑	❑
10. Do you often breathe through your mouth?	....	❑	❑	❑
11. Have you had your tonsils or adenoids removed?	....	❑	❑	❑
12. Have you had baby teeth extracted:				
Due to decay?	....	❑	❑	❑
To make room for permanent teeth?	....	❑	❑	❑
They would not fall out naturally?	....	❑	❑	❑
13. If baby teeth were removed were space maintainers placed to prevent space loss?		❑	❑	❑
14. Have you had a previous orthodontic consultation?	....	❑	❑	❑
15. Are you in good general health?	....	❑	❑	❑

16. Have you had any of the following:

Heart murmur	❑	Epilepsy	❑	Muscular Dystrophy	❑
Anaemia	❑	Liver condition	❑	Rheumatic Fever	❑
AIDS/HIV Positive	❑	Heart condition	❑	Sinusitis	❑
Blood Disorders	❑	Kidney Disease	❑	Speech Problems	❑
Diabetes	❑	Lung Disease	❑	Thyroid Disease	❑

17. Are you currently taking any medications or drugs?
List: ____
18. Do you have <u>any</u> drug sensitivities?
List: ____
19. Is there anything the orthodontist should know regarding your medical/dental history that has not been mentioned?

20. Growth information **for patients under 16 years of age**:

Girls:	Have you started menstruation?	Yes ❑	No ❑
Boys:	Has your voiced changed?	Yes ❑	No ❑

I hereby give Dr. Steven Budd and/or members of his staff permission to release information concerning myself or my child's dental and/or orthodontic health to the family dentist or any other dentist or dental specialists as is deemed necessary. Information released may include x-rays and diagnostic records that pertain to the initial condition, diagnosis, proposed treatment and treatment in progress.

____________________________ Date

____________________________ Signature *(Parent/Guardian for minors)*