We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

www.shineorthodontics.ca

1 ABOUT YOU

Today's Date: ________________

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Other ___________

Name:_______________________________________

I prefer to be called: ________________ □ Male □ Female

Birthday:____________________ Age:____________

□ Single □ Married □ Divorced □ Separated □ Widowed

Address: ____________________________________

E-mail: _____________________________________

Preferred Method of Correspondence: □ Email □ Canada Post

Home #: _______________ Cell #: ________________

Work #: _____________________ Ext: ____________

Occupation: _________________________________

Employer: ___________________________________

Where & When are best times to reach you?

____

What are your orthodontic concerns? _______________

____

Who noticed the orthodontic problem?

□ Self □ Dentist □ Other __________________

Have you consulted an orthodontist regarding your concerns?

____

Any changes in your bite or tooth alignment recently?

____

Have you had any previous orthodontic treatment?

____

What concerns you the most about orthodontic treatment?

□ Appearance □ Cost □ Length of treatment □ Discomfort

□ Result □ Other __________________________

What concerns has your dentist(s) expressed?

□ Bone or gum loss

□ Wear or fractures of teeth

□ Difficulty with cleaning related to tooth alignment

□ Jaw joint or muscle tightness or discomfort

□ Tooth alignment prior to dental work (crowns, bridges, etc.)

Whom may we thank for referring you to our office?

____

Any friends/family members who we are treating?

____

2 SPOUSE INFORMATION

His/Her Name: ________________________________

Employer: ___________________________________

Cell #: ________________ Work #: _______________

Person Responsible for Account: _________________

Home #: _______________ Cell #: ________________

Work #: _____________________ Ext: ____________

Billing address: _______________________________

Relationship: _________________________________

Employer: ___________________________________

3 DENTAL INSURANCE

Insurance Company Name: _______________________

Insurance Company Address: _____________________

Policy No. ___________________________________

Identification No. _____________________________

Policy Holder's Name: _______________ DOB_______

Insurance Company Name: _______________________

Insurance Company Address: _____________________

Policy No. ___________________________________

Identification No. _____________________________

Policy Holder's Name: _______________ DOB_______

4 EMERGENCY CONTACT

Alternative contact in case of emergency

Name: ________________ Relation: ______________

Home #: _______________ Cell #: ________________

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5 DENTAL HISTORY

Dentist's Name:_________________________________ Dentist's Phone #: ____________________________________
Date of Last Visit: ___________________ Reason of Last Visit: ____
Is there any unfinished care to be completed with your dentist? ______________________________________
Frequency of Dental Checkups: □ Twice a year □ Once a year □ Only if a problem exists

Yes No Are you presently in any dental pain? ____
Yes No Are your teeth sensitive to cold, hot, sweet or pressure? ____
Yes No Have there been any injuries to face, mouth or teeth? ____
Yes No Do you generally breath through your mouth? □ Awake □ Asleep _________________________________
Yes No Have teeth been removed? ____
Yes No Do your gums bleed when you brush? ____
Yes No Have you had any periodontal (gum) treatment? ____
Yes No Is your mouth dry? ____

Have you had a history of:
□ Grinding / Clenching teeth □ Muscular soreness around head & neck □ Headaches (more than normal)
□ Ringing in the ears □ Jaw joint soreness □ Jaw joint popping □ Jaw joint clicking

6 MEDICAL HISTORY

Family Doctor's Name: __________________________ Family Doctor's phone #: ______________________________

Yes No Are you currently under a physician's care? ____
Yes No History of a major illness or any operations? ____
Yes No Ever been involved in a serious accident? ____
Yes No Have you been in a high risk group for AIDS? ____
Yes No Are you taking any medication? ____
Yes No Have you ever smoked or chewed tobacco? ____
Yes No Are there concerns of sleep apnea? ____
Yes No Are you pregnant? If yes, week #____

Circle any of the medical conditions below that you have had or currently have

Abnormal bleeding/Hemophilia	Diabetes	Pneumonia	Asthma or Hayfever
Hepatitis/Liver problems	Herpes	Rheumatic Fever	Tuberculosis
High blood pressure	Epilepsy/Seizure	HIV/AIDS	Radiation/Chemotherapy
Congenital Heart Defect	Heart problems	Artificial valves	Heart murmur
Bone Disorders	Nervous Disorders	Kidney problems	Tumor or Cancer
Artificial bones/joints	Arthritis	Anemia	Psychiatric problems

Are you allergic to any of the following?

Aspirin	Tetracycline	Penicillin	Erythromycin	Codeine
Dental Anesthetics	Latex	Any metal/plastic	Other ________________________	

Any other information you feel we should be aware of? ____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Lo to perform a complete orthodontic evaluation.

Signature: _________________________________ Date: ____________________________________