NEWMARKET ORTHODONTICS REGISTRATION FORM

A.PATIENT PERSONAL INFORMATION:

TODAY'S DATE:

FIRST NAME:

SEX: Male ◯ Female ◯

LAST NAME:

PARENT/S FULL NAME :

DATE OF BIRTH: AGE:

ADDRESS:

Street:

Town:

Postal Code: EMAIL ADDRESS:

MAIN - TELEPHONE:

2ND/CELL PHONE:

PATIENT'S DENTIST:

FAMILY PHYSICIAN:

B.FINANCIAL / INSURANCE:

POLICY HOLDER NAME: DATE OF BRITH:

RELATIONSHIP TO PATIENT:

EMPLOYER: WORK TELEPHONE:

INSURANCE COMPANY NAME:

GROUP POLICY: ID/SUBSCRIBER:

SECONDARY INSURANCE INFORMATION (IF ANY):

C. PRESENT STATE OF HEALTH:

1. Are you presently or have you in the past year been under the care of a physician? ◯ YES / NO ◯
   If yes, please explain:
2. Are you presently taking any medication? ◯ YES / NO ◯
   If yes, please describe:
3. Do you have any allergies? ◯ YES / NO ◯
   Please list:
4. Are you in good health? ◯ YES / NO ◯
5. Do you bruise easily or do you have a tendency for prolonged bleeding? ◯ YES / NO ◯
6. Is there anything in your medical history that requires special attention? ◯ YES / NO ◯

D. PAST MEDICAL HISTORY:

1. Have you ever been treated for any of the following?

A. HEART DISEASE ☐ B. HEART MURMUR ☐ C. RHEUMATIC FEVER ☐ D. PROLONGED BLEEDING ☐

E. DIABETES ☐ F. EPILEPSY ☐ G. ASTHMA ☐ H. HAY FEVER ☐

I. ANAEMIA ☐ J. JAUNDICE ☐ K. HEPATITIS ☐ L. AIDS ☐

M. TUBERCULOSIS ☐ N. KIDNEY DISEASE ☐ O. KIDNEY DISEASE ☐

2. Have you ever had a serious illness or been hospitalized? YES / NO
   If yes, please describe:

3. Do you require antibiotic premedication prior to dental procedures? YES / NO

4. Is there anything significant about your medical history that the dentist should know of that has not yet been mentioned? YES / NO
   If yes, please describe:

5. Do You Sleep Well? YES / NO

E. PAST DENTAL HISTORY:

1. Has there been any trauma to the teeth or face? YES / NO
   If yes, please describe:(Age and which teeth involved)

2. Have any teeth been extracted? (Baby teeth or permanent?) YES / NO

3. Have you been informed of any missing or extra permanent teeth? YES / NO

4. Has the patient ever sucked a thumb or finger? If yes, until what age? YES / NO

5. Does the patient have any speech problems? YES / NO

6. Is the patient a mouthbreather? YES / NO

7. Does the patient have frequent colds and/or ear infections? YES / NO

8. Are you aware of either excessive grinding, jaw joint noises or jaw pain? YES / NO

9. Is the patient especially apprehensive towards dental visits? YES / NO

10. Has the patient ever had a bad experience in the dental office? YES / NO

11. Does the patient visit the dentist regularly? YES / NO

12. Was the last dental check up within the past 6 months? YES / NO

F. THE ORTHODONTIC CONCERN(S):

1. What do you feel is the main orthodontic problem?

Crowded teeth ☐ Spacing ☐ Upper front teeth stick out ☐ Facial Balance ☐ Bite Problem ☐

Missing or extra permanent teeth ☐ Don't know ☐

2. Has there been a previous orthodontic consultation or treatment? ◯ YES / NO ◯

3. Who promoted the orthodontic consultation?

Patient ☐ Parent ☐ Dentist ☐

4. What is the patient's attitude towards treatment?

Wants Treatment ☐ Treatment if Necessary ☐ Unwilling But Agrees ☐ Uncooperative ☐

5. Are there other family members or close relatives with a similar arrangement of teeth or a similar facial appearance? ◯ YES / NO ◯

6. Have any other members of the family had orthodontic treatment? ◯ YES / NO ◯