Dr. Christopher H. Tom B.Sc., D.D.S. Cert. Ortho. ORTHODONTIST

ORTHODONTIC PATIENT INFORMATION

Welcome to our office.

The following information is requested to enable me to give you an accurate evaluation of your orthodontic problem during your initial examination in our office. In order for me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records and your health, is confidential. Please circle the appropriate response where indicated. Thank you.

First Last mm dd yr Home Address: Street City Postal Code Person Financially Responsible for Account: Home # Bus# Cell # Email Address: Addresses if different from patient's: Relationship To Patient: Emergency Contact if patient/ legal guardian cannot be reached: Name Relationship Cell# Email Address: Family History Father's Name: Cell# Bus# Email Address: Mother's Name: Cell# Bus# Email Address: Parent's Marital Status: Married Divorced Separated Common Law Patient Living With: Mother Father Spouse Self Other Siblings: None Number of Brothers Number of Sisters Is the patient Covered by insurance for orthodontic treatment? Yes No Number of Insurance policies: 1 2 3 4 Medical History Name of Family Physician Date of Last Check Up: -Allergies (Specify Below) -Drug/Alcohol Dependence -Anemia - Epileps - Heart Niesaec Chest Pain - Heart Attack - Heart Infection - Steroid Therapy - Storoke - Thyroid Disease - Tuberculosis - Diabetes - Heart Infection - Pacemaker - Prospetated - Tuberculosis - Prosphetic Artificial Joint - Shortness of Breath - Additional Information or Specify Conditions Not Listed Above:	Patient'	s Name:		AgeBır	th date// Sex M / F/ Othe
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Family History Father's Name: Cell# Bus# Email Address: Mother's Name: Cell# Bus# Email Address: Parent's Marital Status: Married Divorced Separated Common Law Patient Living With: Mother Father Spouse Self Other Siblings: None Number of Brothers Number of Sisters Siblings: None Number of Brothers Number of Insurance policies: 1 2 3 4 Medical History Name of Family Physician Date of Last Check Up: Has the patient had or ever had any of the following: -Allergies (Specify Below) -Drug/Alcohol Dependence -Anemia - Epilepsy -Hospitalization -Steroid Therapy -Artificial Heart Valve -Emotional Disorders -Jaundice -Stomach Ulcers -Arthritis -Head/Face Injury - Kidney Disease -Stroke -Stroke -Stroke -Stroke -Bone Disorder - Heart Disease/Chest Pain -Mitral Valve Prolapse -Tuberculosis -Diabetes -Heart Murmur - Pacemaker -Pacemaker -Pacemaker -Prosthetic Artificial Joint -Prostness of Breath - Heaptitis/Liver Disease -Shortness of Breath - Additional Information or Specify Conditions Not Listed Above:		Emergency Contact if pat	ient/ legal guardian cannot	be reached:	
Father's Name:Cell#Bus#Email Address:		Name	Relationship	Cell#	Email Address:
Mother's Name: Cell# Bus# Email Address: Parent's Marital Status: Married Divorced Separated Common Law Patient Living With: Mother Father Spouse Self Other	<u>Family</u>	<u>History</u>			
Patient Living With: Mother Father Spouse Self Other Siblings: None Number of Brothers Number of Sisters Siblings: None Number of Brothers Number of Sisters Siblings: None Number of Brothers Number of Sisters Siblings: None Number of Brothers Number of Insurance policies: 1 2 3 4 At the patient Covered by insurance for orthodontic treatment? Yes No Number of Insurance policies: 1 2 3 4 At the patient had or ever had any of the following: Date of Last Check Up: Smoking/Vaping/ Chewing Tobacco Anemia		Father's Name:	Cell#	Bus#	Email Address:
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Siblings:NoneNumber of BrothersNumber of Sisters		Parent's Marital Status: _	Married Divorced	Separated C	Common Law
Medical History Name of Family Physician Date of Last Check Up: Smoking/Vaping/ Chewing Tobacco Steroid Therapy Storoke Stroke Stro		Patient Living With: _	Mother Fath	ner Spouse	Self Other
Medical History Name of Family Physician		Siblings: None	Number of Broth	ers Number of	Sisters
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For Women Only: Are you pregnant? Yes No Maybe Expected Delivery Date?	
Has the patient been under the care of a physician during the past two years, other than for routine examination? Yes / N	0
If YES, condition:	
Current Medications (Prescribed OR over the counter):	
Birth Defects: (Cleft Lip etc.)	
Does the patient have any conditions/therapies that could affect the immune system? (e.g. Leukemia, AIDS, HIV, Chemo Radiation Therapy)	therapy
Has the patient received medical treatment from an allergist or ear, nose and throat specialist (ENT)? Yes No	
If YES, When Dr.'s Name	
Nasal surgeryTonsils removedAdenoids removedTubes in ears	
Dental History	
Name of Family Dentist Date of Last Checkup	
Does the patient have (or had in the past) pain or clicking in jaw joints? Yes No	
Have any teeth been injured due to accidents or blows to the mouth? Yes No Age	
Has the patient been in any vehicle accidents or sports related accidents? Yes No Age	
Has the patient received or been requested to receive speech correction? Yes No Age	
The following habits are of interest. List information as it pertains to this patient:	
Thumb sucking (until age?) Grinding or clenching of teeth Yes No Finger sucking (until age?) Mouth Breathing Yes No Lip-Biting or sucking Yes No Nail Biting Yes No Lips open at rest Yes No Headache Pain/Migraines Yes No Snoring/CPAP Yes No Daytime Sleepiness Yes No	
Has the patient had any unusual dental experiences? (Specify)	
Orthodontic History	
Has the patient ever had a previous orthodontic consultation? Yes No Ever had previous orthodontic treatment? Yes	No
If YES, Date of Treatment: Dr Location:	
Patient's interest in orthodontic treatment: Wants treatmentTreatment if necessaryUnwilling but agreesUnwil	ling
What is the Patient's main concern about their teeth?	
What's the parent's main concern about the patient's teeth?	
How did you find out about our office? Dentist Relative Friend Website Internet Invisalign Yellow Pages Walk-i	n
Other	
Signature of person completing this form:	
Relationship to patient:	