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.

Patient's Name: _____ Age ____Birth date ____/____/____ Sex M / F/ Other
First Last mm dd yr

Home Address: _____ Home Phone _____
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:_____
Has the patient had or ever had any of the following:

-Allergies **(Specify Below)**	-Drug/Alcohol Dependence	-Hormone Disorder	-Smoking/Vaping/ Chewing Tobacco
-Anemia	-Epilepsy	-Hospitalization	-Steroid Therapy
-Artificial Heart Valve	-Emotional Disorders	-Jaundice	-Stomach Ulcers
-Arthritis	-Head/Face Injury	-Kidney Disease	-Stroke
-Asthma	-Heart Attack	-Lung Disease\	-Thyroid Disease
-Bone Disorder	-Heart Disease/Chest Pain	-Mitral Valve Prolapse	-Tuberculosis
-Blood/bleeding disorder	-Heart Infection	-Osteoporosis Meds	
-Cancer	-Heart Murmur	-Pacemaker	
-Chronic Ear Infections	-Hepatitis/Liver Disease	- Prosthetic Artificial Joint	
-Diabetes	-High Blood Pressure	-Shortness of Breath	

Additional Information or Specify Conditions Not Listed Above: _____

_____ Please see reverse side

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 / No

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, Chemotherapy, Radiation 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 surgery _____Tonsils removed _____Adenoids removed _____ Tubes 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 treatment __Treatment if necessary __Unwilling but agrees __Unwilling

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-in

Other _____

Signature of person completing this form: _____

Relationship to patient: _____ Date signed: _____