CALEDONIA
orthodontics

Confidential Patient Information			
First Name:	Middle Initial:	Last Name:	
Nickname:	Birthdate:	Gender:	
Address:	City:	Province:	Postal Code:
Main Phone:	2nd/Cell Phone:	Email:	
Please list the names of any friends or family currently in the practice:			
List any sports, hobbies, or musical instruments played:			
Whom may we thank for referring you to our practice?			

Financial Party Information			
First Name:	Middle Initial:	Last Name:	
Birthdate:	Relationship to Patient:	Email:	
Address:	City:	Province:	Postal Code:
Main Phone:	2nd/Cell Phone:		
Do you have insurance that covers orthodontics?	If so, please name the Insurance Company:		
Secondary Responsible Party			
First Name:	Middle Initial:	Last Name:	
Birthdate:	Relationship to Patient:	Email:	
Address:	City:	Province:	Postal Code:
Main Phone:	2nd/Cell Phone:		

Dental Insurance		
Dentist Name:	Check-up Frequency:	Last Dental Visit:
Has the patient had an orthodontic consult or treatment? If so, when?		
What is the patient's main orthodontic concern?		

Please write YES or No for the Following Questions - Do Not Leave Blank	
Speech problems/therapy?	Grind or clench teeth?
Injury to face, jaw, teeth or mouth?	Discomfort from teeth or gums?
Pain, tenderness or noise in either jaw?	Frequent headaches?
Oral habits (thumb/finger sucking, lip/nail biting)?	Neck/shoulder pain?
Frequent sore throats?	Brush teeth daily?
Floss teeth daily?	Mouth breathing?
Snores during sleep?	Requires premedication?
Any missing or extra permanent teeth?	Apprehensive about dental care?
Frequently chew gum?	
Please provide details as needed:	

Medical History			
Physician Name:	Date of Last Physical:	Patient Health:	
Address:	City:	Province:	Postal Code:
List any medications currently being taken by the patient:			
List any drug allergies or sensitivities that the patient may have:			

Please write YES or No for the Following Questions - Do Not Leave Blank		
Rheumatic Fever	Tuberculosis/Lung Disease	Pneumonia
Liver Disease	Kidney Disease	Heart Attack/Stroke
Heart Disease	Congenital Heart Defect	Heart Murmur
Hemophilia	Hypertension/High Blood Pressure	Prolonged Bleeding/Transfusion

Anemia	HIV/AIDS	Hepatitis
Tonsils/Adenoids Removed	Cancer	Family History of Cancer
Received Radiation Treatment	Growth Problems	Endocrine Problems
Hormone Therapy	Latex/Metal Allergy	Nervous Disorders
Bone Disorders/Bone Loss	Diabetes	Seizures/Epilepsy
Handicaps/Disabilities	Asthma	Arthritis
Treated for Emotional Problems	Ever Been Hospitalized	Take Bisphosphonates (Fosamax, Boniva)
If any of the above medical questions were answered 'Yes', please explain:		

Patients Under 18	
Has patient begun puberty?	If patient is a girl, has menstruation begun?
If patient is a boy, has their voice changed or have facial hair:	
Has the patient grown in the past year or has their show size changed recently:	
Patient's interest in treatment:	Either biological parent ever had orthodontics treatment:

By sharing your email with Caledonia Orthodontics you agree to receive emails and texts from us regarding appointments, insurance, tax receipts, and other practice information, and understand that you can opt out at any time. Your email and personal information will not be shared with 3rd parties at any time. This electronic communication may not be secure. You understand that your patient record may be stored electronically in the cloud on a secure server with back up servers located in the US and Canada and as such subject to any and all US and Canadian laws.

Caledonia Orthodontics supports Personal Information Protection and Electronic Documents Act (PIPEDA). We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. As a result, Caledonia Orthodontics has implemented a Privacy Code, which may be reviewed at any time, and a Privacy Information Officer, Dr. Ashley Phuong.

I hereby give Caledonia Orthodontics permission to release information concerning my dental and/or orthodontic condition to my family physician, dentist or any other dental specialist as is deemed necessary. This includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Caledonia Orthodontics can collect, use and disclose my personal information as set out above in the information about the office privacy policies.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

By typing my name I am applying my electronic signature.

Signature: Date: