Hickman Specialist Group
ORTHODONTICS

NEW PATIENT INFORMATION
v1.3 [CHILD]

Patient

Name _____ Preferred name _____
FIRST LAST

Sex ❑ M ❑ F Birthdate _____ Age _____-_____ Grade _____ School _____
M D Y YRS - MOS

Address _____ Unit # _____ Postal Code _____
#, STREET CITY PROV

Cell # _____-_____-_____ Home # _____-_____-_____ Email _____

Dentist name _____ Dentist office location (street / practice name) _____

Responsible Party 1 (parent/guardian):

Name _____ Relationship to patient _____

Cell # _____-_____-_____ Home # _____-_____-_____ Work # _____-_____-_____

Email _____ Dental insurance ❑ Y ❑ N Company _____

Address: *same as patient* ❑ **OR** _____ Unit # _____ Postal Code _____
#, STREET

Responsible Party 2 (parent/guardian):

Name _____ Relationship to patient _____

Cell # _____-_____-_____ Home # _____-_____-_____ Work # _____-_____-_____

Email _____ Dental insurance ❑ Y ❑ N Company _____

Address: *same as patient* ❑ **OR** _____ Unit # _____ Postal Code _____
#, STREET

To provide the best possible care, we would appreciate your accurate completion of the following:

Yes	No	Medical History
❑	❑	Are you undergoing any current or recent treatment for any medical conditions? Please specify _____
❑	❑	Past **hospitalization** or surgical operations? Please specify _____
❑	❑	Take **any medications** or non-prescription drugs? Please specify _____
❑	❑	Any **allergies** (latex, metals, antibiotics, medications, foods, etc)? Please specify _____
❑	❑	Any past adverse reaction to medications or injections? (i.e. aspirin, dental anesthetics/freezing)
❑	❑	Have you ever been advised not to give blood?
❑	❑	For females only – has the 1st period occurred yet, and if so, approximately how long ago? _____

Does the patient have **any of the following** medical conditions? Please check off only those that apply:

- ❑ High/low blood pressure
- ❑ Chest pain, heart attack
- ❑ Heart conditions (valves, infection, murmur, etc)
- ❑ Stroke
- ❑ Transplants or prosthetic joints
- ❑ Anemia, bruising, prolonged bleeding, blood conditions
- ❑ Stomach ulcers
- ❑ Diabetes
- ❑ Thyroid conditions
- ❑ Asthma
- ❑ Lung conditions (bronchitis, emphysema, tuberculosis)
- ❑ Rheumatic fever
- ❑ Tonsillitis
- ❑ Liver conditions (hepatitis, jaundice, etc)
- ❑ Kidney/urinary conditions
- ❑ Cancer
- ❑ Immune conditions (HIV/AIDS, leukemia, etc)
- ❑ Canker sores / aphthous ulcers
- ❑ Cold sores / blisters
- ❑ Epilepsy / seizures, dizziness / fainting, other neurological conditions
- ❑ Mental disability / spec. need / autism
- ❑ Drug/tobacco/alcohol dependency
- ❑ Other: _____

(please continue on other side)

In order to provide the best possible care, we would appreciate your accurate completion of the following:

Yes	No	Dental History
❑	❑	Was the **last visit** to a dentist within the past 1 year and are checkups / cleanings done at regular intervals?
❑	❑	Any outstanding dental or gum treatment not yet done?
❑	❑	Do any teeth or gums hurt? Please specify _____
❑	❑	Any past complications or issues at a previous dental appointment?
❑	❑	Advised to take **antibiotics** before dental appointments?
❑	❑	History of congenitally **missing or extra teeth**?
❑	❑	Any teeth extracted by the dentist?
❑	❑	Any pain/clicking/popping/locking of the jaw joint?
❑	❑	Have tonsils or adenoids been removed?
		Does the patient:
❑	❑	Grind or clench the teeth?
❑	❑	Breath predominantly with the mouth?
❑	❑	Snore at night?
❑	❑	Often feel not rested in the morning / often feel sleepy during the day?

Yes	No	Orthodontic History
❑	❑	Any previous orthodontic treatment or consultations?
❑	❑	Other family member who have had orthodontic treatment?
❑	❑	Family history of a large lower jaw (underbite)?
❑	❑	Has the patient had any accidents involving the teeth/jaws/chin/nose?
❑	❑	Does the patient suffer from frequent headaches/earaches?
❑	❑	Are there any finger/lip sucking habits, or are there any tongue thrust or nail biting habits?
❑	❑	Are there any difficulties with speech?
❑	❑	Are any sports played that require wearing a mouthguard, or which involve physical contact?
❑	❑	Are any musical instruments played with the mouth?
❑	❑	Do you floss? How often per week? _____ How often do you brush per day? _____

How did you hear about us? (please select all that apply)

❑ Dentist referral ❑ Family member ❑ Friend ❑ Other: _____

❑ Current/past patient of this clinic: _____

Describe the reason for your visit today, and any other information we need to know: _____

_____

_____

_____

Privacy Act and consent to treatment:
At Hickman Specialist Group (HSG), all orthodontic services are performed or supervised by licensed members of the Royal College of Dental Surgeons ("Dental Professionals," DP). By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any DP; (ii) you have been provided and have read a copy of the Privacy Code (PC) for HSG; and (iii) you agree to the collection, use and disclosure of your Personal Information (PI) in accordance with the PC. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of HSG to provide the services you are requesting.

Acknowledgement regarding information provided:
I, the undersigned, certify that I have provided an accurate and complete personal and medical / dental history and have not knowingly omitted any information. I acknowledge that HSG is relying upon the information which I have provided being accurate and complete. I have had the opportunity to ask questions and receive answers regarding my medical / dental history. **Should there be any change in my health status or other information I have provided, I will advise HSG**. As discussed with me, I authorize the DPs and all professional staff working under the supervision and control of the DPs to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my PI among HSG, my medical doctor, any dental laboratory used for the fabrication of appliances, and other health care providers as reasonably necessary. I have been advised that this office maintains a PC and have been provided with a copy and that my PI will be collected, used and disclosed within the guidelines of the PC. I also understand that my PI will be retained by HSG and the other aforementioned institutions in accordance with their current practices, which may involve transfer and retention outside of Canada.

_____ _____ _____

Printed Name (parent/guardian) Signature Date

_____ _____

Reviewed by treating orthodontist Date