



# Hickman Specialist Group

## ORTHODONTICS

NEW PATIENT INFORMATION

v1.3 [ADULT]

### Patient

Name \_\_\_\_\_ Preferred name \_\_\_\_\_

Sex  M  F Birthdate \_\_\_\_\_ Age \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_  
FIRST LAST M D Y YRS - MOS

Address \_\_\_\_\_ Unit # \_\_\_\_\_ Postal Code \_\_\_\_\_  
#, STREET CITY PROV

Cell # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Dentist name \_\_\_\_\_ Dentist office location (street / practice name) \_\_\_\_\_

Dental insurance  Y  N Company \_\_\_\_\_  
(some plans may cover you under your parents' plan up to age 25)

### Emergency contact (please complete as much as possible)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Cell # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

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   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you undergoing any current or recent treatment for any medical conditions? Please specify _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Past <b>hospitalization</b> or surgical operations? Please specify _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Take <b>any medications</b> or non-prescription drugs? Please specify _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Any <b>allergies</b> (latex, metals, antibiotics, medications, foods, etc)? Please specify _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Any past adverse reaction to medications or injections? (i.e. aspirin, dental anesthetics/freezing) |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been advised not to give blood?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>For females only</u> – are you pregnant? If yes, expected delivery date _____                    |

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

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

*(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
<input type="checkbox"/>	<input type="checkbox"/>	Was the <b>last visit</b> to a dentist within the past 1 year and are checkups / cleanings done at regular intervals?
<input type="checkbox"/>	<input type="checkbox"/>	Any outstanding dental or gum treatment not yet done?
<input type="checkbox"/>	<input type="checkbox"/>	Do any teeth or gums hurt? Please specify _____
<input type="checkbox"/>	<input type="checkbox"/>	Any past complications or issues at a previous dental appointment?
<input type="checkbox"/>	<input type="checkbox"/>	Advised to take <b>antibiotics</b> before dental appointments?
<input type="checkbox"/>	<input type="checkbox"/>	History of congenitally <b>missing or extra teeth</b> ?
<input type="checkbox"/>	<input type="checkbox"/>	Any teeth extracted by the dentist?
<input type="checkbox"/>	<input type="checkbox"/>	Any pain/clicking/popping/locking of the jaw joint?
<input type="checkbox"/>	<input type="checkbox"/>	Have tonsils or adenoids been removed?
<i>Does the patient:</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Grind or clench the teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Breath predominantly with the mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Snore at night?
<input type="checkbox"/>	<input type="checkbox"/>	Often feel not rested in the morning and/or often feel sleepy during the day?

Yes	No	Orthodontic History
<input type="checkbox"/>	<input type="checkbox"/>	Any previous orthodontic treatment or consultations?
<input type="checkbox"/>	<input type="checkbox"/>	Other family member who have had orthodontic treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Family history of a large lower jaw (underbite)?
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient had any accidents involving the teeth/jaws/chin/nose?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient suffer from frequent headaches/earaches?
<input type="checkbox"/>	<input type="checkbox"/>	Are there any finger/lip sucking habits, or are there any tongue thrust or nail biting habits?
<input type="checkbox"/>	<input type="checkbox"/>	Are there any difficulties with speech?
<input type="checkbox"/>	<input type="checkbox"/>	Are any sports played that require wearing a mouthguard, or which involve physical contact?
<input type="checkbox"/>	<input type="checkbox"/>	Are any musical instruments played with the mouth?
<input type="checkbox"/>	<input type="checkbox"/>	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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by treating orthodontist

\_\_\_\_\_  
Date