Hickman Specialist Group
ORTHODONTICS

NEW PATIENT INFORMATION
v1.2.7 [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

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

Dentist name _____ Dentist phone number _____-_____-_____

Dentist office location (address or name of practice) _____

Physician name _____

Responsible Party 1 (parent/guardian):

Name _____ Relationship to patient _____

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

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

Email _____ Dental insurance ❑ Y ❑ N Company _____

Responsible Party 2 (parent/guardian):

Name _____ Relationship to patient _____

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

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

Email _____ Dental insurance ❑ Y ❑ N Company _____

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

Yes	No	Medical History
❑	❑	Are you in **good general health**?
❑	❑	Was your last visit to a physician within the past 12 months?
❑	❑	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 a history of **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 / apthous ulcers
- ❑ Cold sores / blisters
- ❑ Epilepsy / seizures, dizziness / fainting, other neurological conditions
- ❑ Mental disability / special needs
- ❑ 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 12 months?
❑	❑	Are checkups and cleanings done at regular intervals (ex: every 6 months)?
❑	❑	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?
		Does the patient:
❑	❑	Grind or clench the teeth?
❑	❑	Breath predominantly with the mouth?
❑	❑	Snore at night?
❑	❑	Often feel not rested in the morning and/or often feel sleepy during the day?
❑	❑	Have tonsils or adenoids been removed?

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?
❑	❑	Has the patient had any accidents involving the teeth/jaws/chin/nose?
❑	❑	Does the patient suffer from frequent headaches/earaches?
❑	❑	Are there any **thumb/finger/lip sucking** habits?
❑	❑	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 _____ 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, all professional orthodontic services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"). 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 Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Hickman Specialist Group; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. 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 Hickman Specialist Group to provide the services you are requesting.

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

_____ _____ _____

Printed Name (parent/guardian) Signature Date

Reviewed by treating orthodontist: _____ Date: _____