

(PLEASE PRINT)

*Please take a few minutes to provide us with the following important information.* Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Surname Given Names

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female E-mail \_\_\_\_\_  
Month Day Year

Address \_\_\_\_\_  
# Street City or Town Postal Code

Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_ Business # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Business # \_\_\_\_\_  
Surname Given Names

Who referred you to this office?  Dentist  Family/Friend  Internet  Yellow Pages.ca  Advertisement  Other \_\_\_\_\_

Who first noticed the need for Orthodontic care?  Dentist  Patient  Other

Reasons for Orthodontic consultation \_\_\_\_\_

Do you consider it a high priority for you to have Orthodontic therapy?  Yes  No

Have you had previous Orthodontic therapy?  Yes  No

Were you satisfied with the results?  Yes  No

Has anyone else in your family had or is having Orthodontic therapy?  Yes  No

If yes, who? \_\_\_\_\_ When? \_\_\_\_\_ and by Whom? \_\_\_\_\_

Was the treatment for a similar problem?  Yes  No

How happy are you with the treatment results? \_\_\_\_\_

What do you think that Orthodontic therapy can do for you? \_\_\_\_\_

Do you consider it:  Necessary  Important  Desirable  Indifferent for you to have Orthodontic therapy?

Are you anticipating a move to another city within the next year?  Yes  No  Possibly

Person financially responsible:  The patient: or

Name \_\_\_\_\_  
Surname Given Name Initial

Address \_\_\_\_\_  
# Street City or Town Postal Code

Telephone # \_\_\_\_\_ Business # \_\_\_\_\_

Do you have a Dental Plan covering Orthodontic Therapy?  No  Yes

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ Name of Ins Co \_\_\_\_\_ Policy # \_\_\_\_\_ ID# \_\_\_\_\_

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**Since it is the policy of this office to bill and receive full payment from our patients, we request that you make payments from your insurance company payable to you.**

**PLEASE NOTE – IT IS IMPORTANT THAT YOU BRING THESE COMPLETED FORMS TO YOUR APPOINTMENT**

# MEDICAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

- Currently under Physician's care?  No  Yes \_\_\_\_\_
- Currently taking medication?  No  Yes \_\_\_\_\_
- Currently under psychological guidance?  No  Yes \_\_\_\_\_
- Have you had the following illnesses/conditions?**
- Allergies  No  Yes \_\_\_\_\_
- Anaemia  No  Yes \_\_\_\_\_
- Arthritis  No  Yes \_\_\_\_\_
- Asthma  No  Yes \_\_\_\_\_
- Birth Defects  No  Yes \_\_\_\_\_
- Bleeding Disorders  No  Yes \_\_\_\_\_
- Cerebral Palsy  No  Yes \_\_\_\_\_
- Diabetes  No  Yes \_\_\_\_\_
- Epilepsy/Seizures  No  Yes \_\_\_\_\_
- Frequent  Colds  Sore throats  No  Yes \_\_\_\_\_
- Hearing Problem  No  Yes \_\_\_\_\_
- Heart & Lung Conditions  No  Yes \_\_\_\_\_
- Hepatitis  No  Yes \_\_\_\_\_
- History of joint prostheses in past 2 years  No  Yes \_\_\_\_\_
- History of antimicrobial therapy  No  Yes \_\_\_\_\_
- HIV/AIDS  No  Yes \_\_\_\_\_
- Jaundice  No  Yes \_\_\_\_\_
- Kidney Disease  No  Yes \_\_\_\_\_
- New Cough or Shortness of Breath  No  Yes \_\_\_\_\_
- New onset of diarrhea  No  Yes \_\_\_\_\_
- New undiagnosed rash, lesion, or break in skin  No  Yes \_\_\_\_\_
- Pregnancy  No  Yes \_\_\_\_\_
- Radiation Therapy  No  Yes \_\_\_\_\_
- Removal of Tonsils and/or Adenoids  No  Yes \_\_\_\_\_
- Rheumatic Fever  No  Yes \_\_\_\_\_
- Other Severe Illness Medical Conditions/Operations Not Listed*  No  Yes \_\_\_\_\_
- Recent exposure to communicable infectious diseases (Measles, mumps, chicken pox, or TB)  No  Yes \_\_\_\_\_
- Family History of prior disease, or symptoms that may be Indicative of CJD, such as sudden onset of dementia  No  Yes \_\_\_\_\_

# DENTAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

Dentist's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

- How long have you been going to the above dentist? \_\_\_\_\_ Years
- How often do you go to your dentist?  Regular Check-ups  infrequently  only for emergencies  Never
- When was your last dental appointment? \_\_\_\_\_ Have you had a recent orthodontic examination? \_\_\_\_\_
- Do you or did you have any of the following?**
- Injury to the head, face, mouth or teeth?  No  Yes \_\_\_\_\_
- Clicking or discomfort in the jaw joints in front of the ears?  No  Yes \_\_\_\_\_
- Sore jaw muscles  No  Yes \_\_\_\_\_
- Tooth grinding or clenching  No  Yes \_\_\_\_\_
- Recurrent headaches?  No  Yes \_\_\_\_\_
- Difficulty in chewing?  No  Yes \_\_\_\_\_
- Speech problem?  No  Yes \_\_\_\_\_
- Extensive dental work or gum problems?  No  Yes \_\_\_\_\_
- Are you concerned with or have reservations about**
- Appearance of your  Face  Lips  Gum  Teeth?  No  Yes \_\_\_\_\_
- Wearing Braces?  No  Yes \_\_\_\_\_
- Co-operation for approximately two years?  No  Yes \_\_\_\_\_
- Some appointments during work/school hours?  No  Yes \_\_\_\_\_
- Any other concerns: \_\_\_\_\_

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Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**SURRIDEO ORTHODONTICS  
PERSONAL INFORMATION CONSENT FORM**

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home address, work address, home telephone numbers, work telephone numbers, mobile phone numbers, and email addresses. (Collectively referred to as "Contact Information").

Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for orthodontic services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimburse from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further Orthodontic examination or treatment.
- To send patients informational material about our Orthodontic practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of Orthodontic treatment.

Financial Information may be collected in order to make arrangements for the payment of Orthodontic services.

We collect information from our patients about their health history, their family history, physical condition, and are used for the purpose of diagnosing orthodontic conditions and providing Orthodontic treatment.

Patients' Medical Information is disclosed:

- To third party health providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of Orthodontic treatment.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other health care professionals for academic teaching purposes.
- To other dentists and dental specialists if the patients with their consent, has been referred by us to the other dentists and dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our Orthodontic practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists and Orthodontists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of the regulatory activities in public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date

Print name

Signature