LAKESHORE ORTHODONTICS

PATIENT NAME: _____
☐ MALE ☐ FEMALE. ☐ OTHER
INSURANCE: ☐ Yes ☐ No ☐ Dual
BIRTHDATE: _____

ADDRESS: _____
CITY: _____
POSTAL CODE: _____ HOME PHONE #: _____

PARENT CELL #:_____

REFERRED BY:_____

DENTIST:_____

Reason for seeking treatment:

_____
REFERRED BY: _____
DENTIST: _____

Is any family member a patient at our office? ☐ No ☐ Yes:

_____

MEDICAL HISTORY:

Medical Doctor: _____

Please check any of the following conditions which apply to you:

☐ Severe Headaches	☐ Sore Throat	☐ Bleeding Gums	☐ Joint Pain
☐ Heart Disease	☐ Convulsions	☐ High Blood Pressure	☐ Poor Vision
☐ Fainting Spells	☐ Chest Pains	☐ Ease of Bruising	☐ Sinus Condition
☐ Ulcers	☐ Tooth Ache	☐ Dizzy Spells	☐ Shortness of Breath

Please check any of the following illnesses you have ever had:

☐ Rheumatic Fever	☐ Asthma	☐ Angina	☐ Psychiatric Care
☐ Hepatitis A,B or C	☐ TB	☐ Heart Disease	☐ Autism Spectrum
☐ Jaundice	☐ Scarlet Fever	☐ Thyroid Problem	☐ Emotional Disturbances
☐ Diabetes	☐ Mononucleosis	☐ Malignant Hyperthermia	☐ Learning Difficulties
☐ Anxiety/Depression	☐ HIV/Aids	☐ ADD/ADHD	☐ Herpes Virus (cold sores)

(PLEASE COMPLETE OPPOSITE SIDE)

Are you suffering from any illness?

_____

Please note any previous hospitalizations and surgeries, and the year:

_____

List any allergies to medicine or food:

_____

List present medication:

_____

How would you describe your health?

_____

Is there anything in your medical history of which the dentist should be aware of, such as dental apprehension, fainting spells, low blood sugar or low blood pressure

_____

(Women:) Are you pregnant now?

_____

DENTAL HISTORY:

1. When was your last check up and cleaning?_____
_____

2. Is there any outstanding dental work that is still required?

_____

3. Have you ever sought an orthodontic consultation or had orthodontic treatment previously?

_____

4. Do you have difficulty chewing?

_____

5. Are you conscious of any pain in your jaw muscle?

_____

DATE: _____

SIGNATURE: _____