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:
_____

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

RESPONSIBLE PARTY INFORMATION:

PARENTS NAME**:**
_____
CELL #: _____
WORK #: _____
EMAIL ADDRESS:
_____
Address: (if different from above)
_____
City: _____
Postal Code:_____

(PLEASE COMPLETE OPPOSITE SIDE

MEDICAL HISTORY:

Patient's Medical Doctor:

_____

Has the patient ever had any of the following illnesses?

☐ Rheumatic Fever ☐ Asthma ☐ Angina ☐ Psychiatric Care
☐ Hepatitis ☐ TB ☐ Heart Disease. ☐ Autism Spectrum
☐ Jaundice ☐ Scarlet Fever ☐ Thyroid Problem ☐ EmotionaL Disturbances
☐ Diabetes ☐ Mononucleosis ☐ Malignant Hyperthermia ☐ Learning Difficulties

1. Is your child taking any medication? ☐ No ☐ Yes:

_____

2. Is your child allergic to any medication or food? ☐ No ☐ Yes:

_____

3. Is there anything in your child's medical history that we should be aware of, such as dental apprehension, fainting spells, low blood sugar or low blood pressure etc? ☐ No ☐ Yes:

_____

4. We desire the very best result possible for your child. Is there any issue that might affect their ability to follow Instructions for brushing, flossing, elastic wear or wearing appliances? (ie. difficulties with learning, co-ordination or manual dexterity?) ☐ No ☐ Yes:

_____

DENTAL HISTORY:

1. Has the child ever had an orthodontic consultation or treatment?
   _____
2. Does the child have any oral habits such as: ☐ Thumb Sucking ☐ Nail Biting

☐ Tongue Thrusting ☐ Teeth Grinding
☐ Finger Sucking ☐ Mouth Breathing

3. How often does your child brush their teeth? ☐ None ☐ 1-2x/day ☐ 3-4x/day ☐ 4-5x/day
4. When was your child's last check up and cleaning and is there any outstanding dental work required?_____
   _____

DATE: _____
SIGNATURE:_____