Cadman & Remmer

CERTIFIED SPECIALISTS IN ORTHODONTICS

Patient Information

To become better acquainted and to be able to offer you the best possible care, we ask that you complete this information form.

Date_____ Patient's Age_____

Patient's Name_____ Birthday_____/_____/_____ ☐ Male ☐Female

Last First MI M D Y

Address_____City_____Prov_____ PC_____

Home Phone_____ Cell Phone _____Work Phone_____

Email_____ Employer (Optional) _____

Dentist's Name_____ Family members seen by us_____

How did you hear about our office? ☐ Dentist ☐ Friend ☐ Family Member ☐ Website ☐ Staff Member

☐ Other_____

(Please elaborate)

Parent Information (please complete if patient is under the age of 18)

Patient lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other (please specify) _____

Person responsible for account_____Relation_____

Address_____City_____Prov_____PC_____

(If different from the patient)

Home Phone _____Work Phone _____Cell Phone_____

Email_____

Mother's Information

☐ Stepmother ☐ Guardian

Name_____

Address_____

(if different from patient)

Home Phone_____

Work Phone_____

Cell Phone_____

Email_____

Father's Information

☐ Stepfather ☐ Guardian

Name_____

Address_____

(if different from patient)

Home Phone_____

Work Phone_____

Cell Phone_____

Email_____

Insurance Information

Our office charges the patient/parent/guardian directly for all professional services rendered. We will complete the necessary forms so that you can receive the reimbursement to which you are entitled under your policy.

Do you have orthodontic coverage? ☐ Yes ☐ No ☐ Unsure

Primary

Insurance company name_____

Subscriber's name_____

Secondary

Insurance company name_____

Subscriber's name_____

Do you have coverage through: ☐ NIHB ☐ Social Assistance(Sask Health) ☐ Family Income Plan ☐ Cleft Palate Clinic

Dental History

Reason for orthodontic consultation (chief concern) _____

Is the patient happy with his/her smile? ☐ Yes ☐ No If not, what would he/she change? _____

Has the patient ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Does the patient want treatment? ☐ Yes ☐ No ☐ Unsure

Has the patient now or ever experienced problems with their jaw joints (TMJ)? ☐ Yes ☐ No

If yes, please specify_____

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

If yes, please specify_____

Has the patient had or presently have any of the following habits? ☐ Thumb/finger sucking ☐ Lip biting ☐ Snoring ☐ Grinding

☐ Clenching ☐ Chronic mouth breathing ☐ Speech problems ☐ Tongue thrusting ☐ Chewing/eating problems ☐ Sinus problems ☐ Nail biting

Does the patient see the dentist regularly? ☐ Yes ☐ No How often does the patient brush? _____

How often does the patient floss? _____

Medical History

Physician's Name_____ Physician's Phone #_____Sask Healthcare #_____

Patient's current physical health is ☐ Good ☐ Fair Is the patient currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain_____

Does the patient require antibiotics before dental treatment? ☐ Yes ☐ No If yes, please explain_____

Is the patient taking any prescription or over the counter drugs? ☐ Yes ☐ No List all_____

Does the patient have any allergies? ☐ Yes ☐ No List all_____

Does the patient use tobacco? (smoking or chewing) ☐ Yes ☐ No

For women: Is the patient pregnant? ☐ Yes ☐ No ☐ Unsure

DOES THE PATIENT HAVE NOW, OR EVER HAD ANY OF THE FOLLOWING?

	Y	N		Y	N		Y	N
Anemia/Blood Transfusion/Hemophilia	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
AIDS/HIV	☐	☐	Difficulty breathing	☐	☐	Hospitalized for any reason	☐	☐
Alcohol/Drug Abuse	☐	☐	Emotional/Psychiatric problems	☐	☐	Kidney problems	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐
Arthritis	☐	☐	Epilepsy/Seizures/Fainting	☐	☐	Lupus	☐	☐
Artificial joints/bones/valves	☐	☐	Fetal alcohol syndrome	☐	☐	Rheumatic/Scarlet fever	☐	☐
Asthma	☐	☐	Frequent headaches	☐	☐	Shingles	☐	☐
Cancer/Chemotherapy/Radiation treatment	☐	☐	Glaucoma	☐	☐	Sickle cell disease/traits	☐	☐
Colitis/Crohn's	☐	☐	Hay fever	☐	☐	Tuberculosis	☐	☐
Cystic Fibrosis	☐	☐	Hepatitis	☐	☐	Ulcers	☐	☐
Congenital heart defect/Mitral valve prolapse	☐	☐	Herpes	☐	☐	Venereal Disease	☐	☐
			Heart murmur	☐	☐			

If yes to any of the above, please explain_____

Describe any other medical condition not listed_____

Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Parent/Guardian_____Date_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient/parent named herein.

Initial: _____ Date: _____

Comments:_____

_____

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