



PATIENT INFORMATION FORM

Today's Date: \_\_\_\_\_

DEMOGRAPHIC INFORMATION

Patient's Name: \_\_\_\_\_
Address: \_\_\_\_\_
Date of Birth: \_\_\_\_\_
Home Telephone: \_\_\_\_\_
Work Telephone: \_\_\_\_\_
Patient's Dentist: \_\_\_\_\_
Mother's Name: \_\_\_\_\_
Father's Name: \_\_\_\_\_

MEDICAL HISTORY

Patient's Physician: \_\_\_\_\_
Is patient under care of physician now?
If yes, for what reason \_\_\_\_\_
Is patient taking any medications presently?
Has patient ever had serious illness or been hospitalized?
Does patient have allergies?
Has patient had tonsils removed?
Has patient ever had or been treated for (check all that apply):
Diabetes, Bone disorder, Anemia, Kidney disease, Rheumatic fever, Pneumonia, Liver disease, Hepatitis, Gland problems, AIDS or HIV positive, Heart trouble/murmur, Arthritis, Asthma, Prolonged bleeding, Nervous disorder, Epilepsy
Females: Has menstruation started?
Males: Has voice changed?

DENTAL HISTORY

Why is patient seeking orthodontic treatment?
Other, specify \_\_\_\_\_
Date of last dental examination \_\_\_\_\_
Did patient have x-rays?
Has patient ever had (check all that apply):
Implants, Extractions, Spacers/retainers, Orthodontics
Is patient nervous about seeing the Dentist?
Has patient had bad dental experiences?
How often does patient brush?
How often does patient floss?
Does patient clench or grind teeth?
Has patient had injury to face/jaws/teeth?
Has patient ever sucked thumb/finger/lip?
Have siblings had orthodontic treatment?
If so, describe \_\_\_\_\_
Have the patient's teeth erupted?

TMJ HISTORY

Does patient have frequent headaches?
Has patient noticed jaw joint noises?
Type of noise:
Has patient had jaw joint pain?
Has patient ever had jaw "lock"?
Has patient had treatment for jaw joint pain?
Has patient had jaw joint x-rays for jaw joint problems?

## PATIENT CONSENT

I, \_\_\_\_\_ (parent/guardian) for \_\_\_\_\_ (patient) do hereby authorize the performance of required dental and orthodontic services by the Orthodontist of Icon Orthodontics, their assistants or designees.

I further authorize the administration of those dental and orthodontic treatments as are deemed necessary by the Orthodontist.

I accept full responsibility for all financial agreements.

I hereby sign on the patient's behalf as legal guardian.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### INSURANCE INFORMATION

Do you have coverage for orthodontic treatment?  yes  no Additional Insurance?  yes  no

#### Insurance One:

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

M/D/Y

Employer: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

#### Insurance Two:

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

M/D/Y

Employer: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

### PERSONAL INFORMATION CONSENT

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. As a requirement of the federal and provincial governing bodies we have privacy policies in place. If you would like further information on the privacy policies of this office please ask one of our staff and we would be happy to answer any questions you may have.

I consent to the collection, use and disclosure of personal information for \_\_\_\_\_ (patient name) as set out above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Print name