HURD TOMSON
ORTHODONTICS

ADULT

HEALTH HISTORY FORM

Patient's Name _____
First Last

Sex: M F Birthdate: _____
Day/Month/Year

Address: _____
Street City Postal Code

Home Phone: _____ Work Phone _____ Cell Phone: _____

Email Address_____

Would you prefer to receive correspondence from our office by mail or email? Mail____ Email ____

Person Financially Responsible: Self _____ Other: *(Please Specify:* _____

Do You Have General Dental Insurance Y N Do you have Orthodontic Insurance? Y N

Patient's Dentist: _____ Patient's Physician : _____

How Did You Hear About Our Practice?

Dentist □ Friend/Family/Neighbour? □ Website? □ Advertisement? □ Other?_____

What is Your Reason For Arranging and Orthodontic Consultation ? _____

Has Any Other Family Member a Similar Jaw Problem? _____

Have you previously worn any kind of orthodontic appliance such as retainers, braces, spacers etc?_____

Have we treated any other family member? If so please list names _____

Please Complete Second Page

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ORTHODONTICS

DENTAL/MEDICAL HISTORY

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ORTHODONTICS

Difficulty Breathing Through Nose? Y N

Unusual Number of Headaches? Y N

Do Jaws Click, Crack or Lock Upon Opening? Y N

Do You Grind or Clench Your Teeth? Y N

Are you under a Physician;s Care? Y N

Are you Taking Any Medication? Y N If so, please describe _____

Do You Have any Allergies or Drug Reactions? Y N If so, please describe _____

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE **CIRCLE** EACH QUESTION YES OR NO)

ASTHMA	YES	NO
HAYFEVER	YES	NO
BLEEDING DISORDER	YES	N O
HEPATITIS	YES	NO
MONONUCLEOSIS	YES	NO
REHEUMATIC FEVER	YES	NO
EPILEPSY	YES	NO
DIABETES	YES	NO
KIDNEY DISEASE	YES	NO
LIVER DISEASE	YES	NO
HEART PROBLEMS	YES	NO
LATEX ALLERGY	YES	NO
HIV	YES	N O

ANY ADDITIONAL COMMENTS?

Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law. Only necessary information is collected and we only share information with your consent.

I hereby consent that Dr. Hurd, Dr. Tomson or his designated staff may release any informaiton pertaining to orthodontic treatment to my dentist or related health professional.

Date: _____ Patient Signature: _____