HURD TOMSON ORTHODONTICS

PATIENT INFORMATION – CHILD

HURD TOMSON ORTHODONTICS

Patient Name First _____ Last_____

Home Address: _____ City_____ Postal Code_____

Home Phone _____ Birthdate _____ Sex: M F Age _____

Father's Name _____ Work Phone: _____ Cell Phone _____

Mother's Name _____ Work Phone: _____ Cell Phone _____

Mother's Email: _____ Father's Email_____

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

If Mother or Father has a different address than the child, please specify: Mother: Address _____

Father: Address_____

Person Financially Responsible : (Please Circle) Mother Father Both Parents

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

Please List Any of Your Child's Sports or Hobbies: _____

What is Your Reason for Arranging and Orthodontic Consultation? _____ _____

Has the Patient previously worn any orthodontic appliance such as retainers, braces, spacers etc? Y N

Has any other family member a similar bite or jaw problem? Y N

Have we treated any other family member? Y N If so, please list names: _____

Siblings Names and Ages: _____

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

How did you hear of our practice? (Please Circle) Dentist Friend/Family/Neighbour Website Other

Please Complete Second Page

HURD TOMSON
ORTHODONTICS

DENTAL/MEDICAL HISTORY

HURD TOMSON
ORTHODONTICS

Does Patient Have Any of the Following? Please circle Y or N to EACH question

Has Patient Sucked Thumb or Finger?	Y	N	If so, when did habit stop _____
Have Tonsils or Adenoids Been Removed?	Y	N	
Difficulty Breathing Through Nose?	Y	N	
Unusual Number of Headaches?	Y	N	
Do Jaws Click, Crack or Lock Upon Opening?	Y	N	
Does Patient Grind or Clench Teeth?	Y	N	
Is Patient Under a Physician's Care?	Y	N	If so, please describe _____
Is Patient Taking Any Medication?	Y	N	If so, please list _____
Does Patient Have Any Allergies or Drug Reactions?	Y	N	If so, please describe: _____
Nickel Allergy or Sensitivity to Jewelry?	Y	N	Latex Allergy? Y N

Circle Y or N to Each of the Following Questions:

Abnormal Bleeding	Y	N	Hepatitis/Liver problems	Y	N
Asthma or Hayfever	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	HIV/Aids	Y	N
Epilepsy	Y	N	Kidney Problems	Y	N
Heart Problems	Y	N	Nervous Disorders	Y	N
Liver Disease	Y	N			

Any additional medical issues or concerns?

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 INFORMATION PERTAINING TO ORTHODONTIC TREATMENT TO MY DENTIST OR RELATED HEALTH PROFESSIONAL:

Date: _____ Parent/Guardian Signature : _____