Embrace ORTHODONTICS

Dr. Kirby Cadman, D.M.D., M. Sc.
Dr. James Stephenson, D.M.D., M. Cl.D

PATIENT INFORMATION

Patient's Name: _____ Prefers to be called: _____ Today's Date: _____

❑ Male ❑ Female Birthdate: _____ Age: _____ School (optional):_____

Mailing Address: _____ Town/City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer (optional): _____

ACCOUNT 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: _____ Work Phone: _____

Home Phone: _____ Cell: _____ Email: _____

Billing Address: _____ Town/City:_____ Postal Code: _____

How would you like to receive appointment reminders? ❑ Text Message ❑ Email ❑ Voice Call ❑ All

MOTHER'S INFORMATION:

Name: _____ ❑ Step Mother ❑ Guardian Cell Phone: _____

Home Phone: _____ Work Phone:_____ Email: _____

Address *(if different from patient)* _____

FATHER'S INFORMATION

Name: _____ ❑ Step Father ❑ Guardian Cell Phone: _____

Home Phone: _____ Work Phone:_____ Email: _____

Address *(if different from patient)* _____

INSURANCE INFORMATION

Our office charges the patient/parent/guardian directly for all professional services rendered.

Do you have orthodontic coverage? ❑ Yes ❑ No ❑ Unsure Private Insurance ❑ Yes ❑ No

Primary Dental Insurance: Name of Policy Holder (subscriber):_____

Secondary Dental Insurance: Name of Policy Holder (subscriber): _____

Saskatchewan Health No. or First Nations (Treaty) No. (if applicable): _____

Name of Social Worker (if applicable): _____

EMERGENCY CONTACT

Who we should contact: _____ Relation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

MEDICAL HISTORY

Medical Doctor: _____ Is the patient under the care of a physician? ❑ Yes ❑ No

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? If yes, Please explain: _____

Does the patient have any allergies? (Example: Food, Metal, Latex, Acrylic): _____

Does the patient use tobacco? (smoking/chewing) ❑ Yes ❑ No *For Women:* Is the patient pregnant? ❑ Yes ❑ No ❑ Unsure

Embrace ORTHODONTICS

Dr. Kirby Cadman, D.M.D., M. Sc.
Dr. James Stephenson, D.M.D., M. Cl.D

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

- ❑ Anemia/Blood Transfusion/ Hemophilia
- ❑ AIDS/HIV
- ❑ Alcohol/Drug Abuse
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints / Bones / Valves
- ❑ Asthma
- ❑ Cancer/Radiation/Chemo
- ❑ Colitis/Crohn's
- ❑ Cystic Fibrosis
- ❑ Congenital Heart Defect
- ❑ Mitral Valve Prolapse
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Emotional/Psychiatric Problems
- ❑ Emphysema
- ❑ Epilepsy/Seizures/Fainting
- ❑ Fetal Alcohol Syndrome
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Hepatitis
- ❑ Herpes
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Hospitalized for any reason
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Lupus
- ❑ Rheumatic/Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease Traits
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease

If YES to any of the above, please explain: _____

Describe any other medical condition not listed:_____

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF:

- ❑ Jaw Joint Pain?
- ❑ Jaw Joint Locking?
- ❑ Teeth Grinding?
- ❑ Headaches?
- ❑ Oral Habits? (Thumb, etc.)
- ❑ Mouth breathing?
- ❑ Problems with gums?
- ❑ Root Canals?
- ❑ Difficulty chewing?
- ❑ Speech Problem?
- ❑ Extensive dental treatment?

Has the patient ever had injuries to jaws or teeth? Explain: _____

Any personal concerns regarding your/your child's teeth? Explain: _____

How often do you visit the dentist? _____ Family members seen by us _____

Referred by: _____ Dentist's Name: _____

How did you hear about our office? ❑ Dentist ❑ Friend ❑ Family ❑ Website ❑ Social Media ❑ Staff Member: _____

❑ Other: _____

Any additional comments or information: _____

_____

The best orthodontic treatment is based on a friendly mutual understanding between provider and patient.

We invite you to discuss with us any questions regarding our services.

- ❑ **I authorize the staff to perform any services needed during diagnosis and treatment.**
- ❑ **I authorize the provider to release any treatment information required to assist the processing of insurance claims.**
- ❑ **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform the office of any changes to the information I have provided.**

Signature _____ Date:_____

(Patient / Parent / Guardian)

FOR OFFICE USE ONLY

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

Signature _____ Date:_____