ICON ORTHODONTICS

Today's Date (mm/dd/yyyy): ____________________

DEMOGRAPHIC INFORMATION

Patient's Name (Last, First, Initial): ____________________

Address: ____________________ City: ____________________ Postal Code: ____________________

Date of Birth (mm/dd/yyyy): ____________________ Age: ____________________ Gender: ❑ Male ❑ Female

Home Telephone: ____________________ Cell Number: ____________________

Work Telephone: ____________________ Email Address: ____________________

❑ I agree to receive email messages from Icon Orthodontics which may include appointment reminders, newsletters, upcoming events and important notifications. You can withdraw your consent at any time.

Patient's Dentist: ____________________ Referred by: ____________________

MEDICAL HISTORY

Patient's Physician: ____________________ Is patient under care of physician now? ❑ Yes ❑ No

If yes, for what reason: ____________________ Is patient considered to be in good health? ❑ Yes ❑ No

Is patient taking any medications presently? ❑ Yes ❑ No If yes, please list: ____________________

Has patient ever had serious illness or been hospitalized? ❑ Yes ❑ No If yes, describe: ____________________

Does patient have allergies? ❑ Yes ❑ No If yes, specify: ____________________

Has patient had tonsils removed? ❑ Yes ❑ No

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 Alberta Health requires screening for the following: ❑ Frequent Diarrhea ❑ Skin Rash ❑ Persistent Cough

Women Only: Are you pregnant or think you may be pregnant? ❑ Yes ❑ No

DENTAL HISTORY

Why is patient seeking orthodontic treatment? ❑ Appearance ❑ Bite problems ❑ Dentist referral Other, specify: ____________________

Date of last dental examination (mm/dd/yyyy): ____________________ Did patient have x-rays? ❑ Yes ❑ No ❑ unsure

Has patient ever had (check all that apply): ❑ Fillings ❑ Crowns/bridges ❑ Implants ❑ Extractions ❑ Spacers/retainers ❑ Orthodontics

Is patient nervous about seeing the Dentist? ❑ Yes ❑ No Has patient had bad dental experiences? ❑ Yes ❑ No

How often does patient brush? ____________________ How often does patient floss? ____________________

Does patient clench or grind teeth? ❑ Yes ❑ No

Has patient had injury to face/jaws/teeth? ❑ Yes ❑ No If yes, describe: ____________________

Has patient ever sucked thumb/finger/lip? ❑ Yes ❑ No Have siblings had orthodontic treatment? ❑ Yes ❑ No

If so, describe: ____________________

TMJ HISTORY

Does patient have frequent headaches? ❑ Yes ❑ No If yes, describe: ____________________

Has patient noticed jaw joint noises? ❑ Yes ❑ No If yes: ❑ Previously ❑ Currently

Type of noise: ❑ CLICKING ❑ left ❑ right ❑ POPPING ❑ left ❑ right ❑ GRATING ❑ left ❑ right

Has patient had jaw joint pain? ❑ Yes ❑ No Has patient ever had jaw "lock"? ❑ Yes ❑ No

Has patient had treatment for jaw joint pain? ❑ Yes ❑ No Has patient had jaw joint x-rays for jaw joint problems? ❑ Yes ❑ No

ICON ORTHODONTICS

PATIENT CONSENT

I, ______________________________ (patient) do hereby authorize the performance of required dental and orthodontic services by the Orthodontist of Icon Services, 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.

____
Patient Name

______________________________ ______________________________
Witness Date (mm/dd/yyyy)

INSURANCE INFORMATION

Do you have coverage for orthodontic treatment? ❑ Yes ❑ No Additional Insurance? ❑ Yes ❑ No

Insurance One:

Name of Insured: ______________________________ Date of Birth (mm/dd/yyyy): ______________

Employer: ______________________________

Name of Insurance Company: ______________________________

Policy No.: ______________________________ ID No.: ______________

Insurance Two:

Name of Insured: ______________________________ Date of Birth (mm/dd/yyyy): ______________

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 as set out above.

______________________________ ______________________________
Signature Date (mm/dd/yyyy)