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: _____

Patient's Dentist: _____ Referred by: _____

Mother's Name: _____ Mother's Work Telephone: _____ Cell#: _____

Mother's Address: _____ Mother's Email: _____

Father's Name: _____ Father's Work Telephone: _____ Cell#: _____

Father's Address: _____ Father's Email: _____

❑ 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.

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

Females: Has menstruation started? ❑ Yes ❑ No Is patient pregnant? ❑ Yes ❑ No

Males: Has voice changed? ❑ 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: _____

Have the patient's teeth erupted? ❑ Early ❑ Average ❑ Late

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, _____ (parent/guardian) for _____ (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.

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

_____ _____

Parent/Guardian Relationship to patient

_____ _____

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 for _____ (patient name) as set out above.

_____ _____

Signature of Parent/Guardian Date (mm/dd/yyyy)

_____

Print Name