GRAND RIVER ORTHODONTICS
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ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of this form.

PLEASE TELL US ABOUT YOURSELF

Patient Name: _____ Age: _____ Birth Date: _____ Gender: _____

Home Address: _____ City: _____ Postal Code: _____

Phone (Residence): (_____) _____ Phone (Mobile): (_____) _____

Phone (Business): (_____) _____ Email: _____

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Other ❑

PERSON RESPONSIBLE FOR FINANCIAL MATTERS

Name: _____ Phone (Residence): (_____) _____

Address: _____ Phone (Business): (_____) _____

_____ Place of Employment: _____

Relationship to the Patient: _____ Email: _____

	Family Dentist	Family Physician	Referred By
Name:	_____	_____	_____
Address:	_____	_____	_____
City, Prov.:	_____	_____	_____

MEDICAL HISTORY (please circle any applicable items)

Y N Allergies: Latex ❑ Metal ❑
Y N Anemia
Y N Arthritis
Y N Artificial Joints/Valves
Y N Asthma/Difficulty Breathing
Y N Birth Defects/Congenital Defects
Y N Cancer
Y N Cold Sores
Y N Diabetes
Y N Endocrine Problems
Y N Emotional Problems
Y N Epilepsy/Seizures
Y N Headache/Migraine
Y N Heart Condition/Murmur
Y N Head or Face Injury
Y N Hemophilia/Bleeding Problems
Y N Hepatitis
Y N Herpes
Y N HIV Positive
Y N Kidney/Liver Disease
Y N Mitral Valve Prolapse
Y N Oral Ulceration
Y N Previous Surgery
Y N Rheumatic Fever
Y N Thyroid Problems
Y N Tuberculosis
Y N Other(Describe Below)

❑ **NO TO ALL OF THE ABOVE**

If "yes", please explain: _____

_____

_____

Have you been under the care of a physician during the past 2 years, (other than for routine examinations)? No❑ Yes ❑

If "yes" please explain: _____

_____

_____

_____

Do you require pre-medication (antibiotics) for dental procedures? No ❑ Yes ❑

Please list any medications (including dosage/frequency) currently taken: _____

_____

_____

RESPIRATORY HISTORY Do you:

1. Have allergies to: Latex: _____ Metal: _____ Medications: _____
   Food: _____ Seasonal: _____ Other: _____
2. Breathe through your mouth? Seldom ❑ Sometimes ❑ Always ❑ When? Daytime ❑ or Night-time ❑
3. Snore when sleeping? No ❑ Yes ❑
4. Have frequent colds? No ❑ Yes ❑
5. Have frequent "stuffy nose"? No ❑ Yes ❑
6. Have frequent sore throat or tonsillitis? No ❑ Yes ❑
7. Have chewing or swallowing difficulties? No ❑ Yes ❑
8. Have you received medical treatment from an allergist or ear, nose, and throat (ENT) specialist? No ❑ Yes ❑
   If "yes" when: _____ By whom: _____
   Nasal Surgery (Date): _____ Tonsils Removed (Date): _____ Adenoids Removed (Date): _____

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Have you had any unusual dental experiences? No ❑ Yes ❑

If "yes" please explain: _____

Date of last dental checkup: _____ Were your teeth cleaned? No ❑ Yes ❑

Have you ever been treated for TMJ (TMD or "Jaw Joint") problems? No ❑ Yes ❑

Do you have:

1. Difficulty with mouth opening? No ❑ Yes ❑
2. Pain or clicking in the jaw joint? No ❑ Yes ❑
3. Pain on chewing, yawning, or opening wide? No ❑ Yes ❑
4. Pain in or about the ears or cheeks? No ❑ Yes ❑
5. A bite that feels "uncomfortable" or "unusual"? No ❑ Yes ❑
6. A jaw that "locks"; "gets stuck" or "goes out"? No ❑ Yes ❑
7. Noises in or from the jaw joint No ❑ Yes ❑

The following habits are of interest. List information as it pertains to you:

1. Thumb-sucking ❑; Finger-sucking ❑; Lip-sucking ❑ until _____ (age) No ❑ Yes ❑
2. Grinding ❑ or Clenching ❑ of the teeth When? Daytime ❑ or Night-time ❑ No ❑ Yes ❑
3. Tongue thrusting or other functional problems No ❑ Yes ❑

Have you had a previous orthodontic consultation? No ❑ Yes ❑ or previous orthodontic treatment? No ❑ Yes ❑

Date: _____ Dr. _____ City, Province: _____

If "yes" please explain: _____

_____

Why do you seek this consultation (chief complaint)? _____

_____

_____

What is expected from orthodontic treatment? _____

_____

_____

Signature: _____ Date: _____