GRAND RIVER ORTHODONTICS
Dr. Greg S. Dugas BSc, DDS, MSc, D.ORTHO, FRCD(C)

222 Fairview Drive, Suite 103
Brantford, Ontario N3R 2W9
phone: 519.759.2590
fax: 519.759.2951

191 Queensway West
Simcoe, Ontario N3Y 2M8
phone: 519.426.6440
fax: 519.426.1039

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

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

PLEASE TELL US ABOUT YOUR CHILD

Patient Name: _____ Age: Years_____ Months____ Grade: _____ Gender: _____

Home Address: _____ Birth Date: _____

City: _____ Postal Code: _____ Home Phone: (_____) _____

Email: _____ School: _____

FAMILY HISTORY

	Mother	Father
Name:	_____	_____
Address: (If same:❑)	_____	(If same:❑) _____
Phone (Residence):	(_____) _____	(_____) _____
Phone (Mobile):	(_____) _____	(_____) _____
Place of Employment:	_____	_____

Patient Living With: Both Parents: ❑ Mother: ❑ Father: ❑ Other Provider: ❑

Other Family Members Seen By Us: _____

Siblings (Name and Age): _____

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: _____

Has your child been under the care of a physician during the past 2 years (other than for routine examinations)? No❑ Yes ❑

If "yes" please explain: _____

Does your child require pre-medication (antibiotics) for dental procedures? No ❑ Yes ❑

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

GROWTH INDICATION Has your child reached puberty? No ❑ Yes ❑

Girls: Has she reached menstruation? If "yes" when?_____ No ❑ Yes ❑

Boys: Has his voice changed? If "yes" when?_____ No ❑ Yes ❑

RESPIRATORY HISTORY Does your child:

1. Have allergies to: Latex: _____Metal: _____Medications: _____

   Food: _____Seasonal: _____Other:_____
2. Breathe through their 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. Has your child 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

Has your child had any unusual dental experiences? No ❑ Yes ❑

If "yes" please explain: _____

Date of last dental checkup: _____Were the patient's teeth cleaned? No ❑ Yes ❑

Has your child ever been treated for TMJ (TMD or "Jaw Joint") problems? No ❑ Yes ❑

Does your child 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 your child:

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 ❑

Has your child 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: _____