ACQUAINTANCE FORM

Bayview Hill ORTHODONTICS

PATIENT INFORMATION **I am responsible for the orthodontic account** ☐ ✓ **My insurance plan covers orthodontic treatment** Y N ?✓

Patient's Name: M✓F ***Mr./Dr./Mrs./Ms./Miss*** _____Name I prefer to be called:_____

Birthday: MM / DD / YYYY Age:_____ H❩:_____ C❩:_____

Address: _____City:_____ Postal Code:_____

Email:_____ W❩:***(Adult patients)***:_____ ***Minors,*** Name of school:_____

Minors, What grade are you in: _____ Who may we thank for referring you to our office? _____

PLEASE COMPLETE If PATIENT IS A MINOR

FATHER/GUARDIAN INFORMATION **I am responsible for the orthodontic account** ☐ ✓ **My insurance plan covers orthodontic treatment** Y N ?✓

Name:_____ Relationship to patient:_____ Marital status:_____

(If different)Address: _____City:_____Prov:_____Postal:_____

H❩: _____C❩:_____W❩:_____ Email_____

MOTHER/GUARDIAN INFORMATION **I am responsible for the orthodontic account** ☐ ✓ **My insurance plan covers orthodontic treatment** Y N ?✓

Name:_____ Relationship to patient:_____ Marital status:_____

(If different) Address: _____City:_____Prov:_____Postal:_____

H❩: _____C❩:_____W❩:_____ Email:_____

MEDICAL HISTORY OF THE PATIENT

	Y	N		Y	N		Y	N		Y	N
Heart Murmur	☐	☐	Diabetes	☐	☐	Nickel / Metal Sensitivity	☐	☐	Tonsils removed	☐	☐
Mitral Valve Prolapse	☐	☐	Hepatitis A, B or C	☐	☐	*(Costume jewelry, skin reaction)*			Tendency to colds	☐	☐
Rheumatic Fever	☐	☐	HIV / AIDS	☐	☐	Latex Allergy	☐	☐	Tendency to sore throats	☐	☐
Heart Disease	☐	☐	Blood Disease	☐	☐	Penicillin Allergy	☐	☐	Tendency to ear infections	☐	☐
Artificial Heart Valve	☐	☐	Prolonged Bleeding	☐	☐	Other Allergies ***(please list below)***	☐	☐	Autism	☐	☐
Artificial Joints	☐	☐	Liver / Kidney Disease	☐	☐	Do you carry an EpiPen	☐	☐	Attention Deficit Disorder *(ADD / ADHD)*	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐	Asthma	☐	☐	***Minors***, reached puberty yet	☐	☐

- **If YES to any of the above** (*or have any history of major illness, conditions and/or operations*) please give pertinent information: _____
- List any prescription medication being taken & reasons:_____
- List any allergies or drug sensitivities: _____
- Name of your Family Physician: _____ W❩Physician: _____

DENTAL HISTORY OF THE PATIENT

	Y	N		Y	N		Y	N
Mouth breather	☐	☐	Jaw joint problems	☐	☐	Had previous orthodontic exams	☐	☐
Frequent Canker / Cold Sores	☐	☐	Clenching and/or Grinding teeth	☐	☐	Family member had orthodontic treatment	☐	☐
Speech problems	☐	☐	Injuries to face, mouth or teeth	☐	☐	*Name of Orthodontist:* _____		
Missing / Extra Teeth	☐	☐	Apprehensive towards dental visits	☐	☐	Thumb / Finger / Blanket sucking habit	☐	☐
						Habit stopped at age:_____; Habit still occurring	☐	☐

- **Reason for orthodontic consultation:**_____
- Name of your Family Dentist: _____ W❩ Dentist: _____ Last dental visit:_____

Share with us your sports, hobbies or musical instruments played: _____

RELEASE OF INFORMATION: ***I hereby give Dr. Sharma-Sayal and/or members of her staff permission to exchange information concerning myself or my child's dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary. This information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.***

Signature (***If Minor***, Parent / Guardian Sign): _____Date Signed: _____