CLEARLY
ORTHODONTICS

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Medical History Form

PATIENT INFORMATION

Name: _____ Gender: M / F Date of Birth: ____ / ____ / ____
Last First Preferred Name YYYY / MM / DD

Address: _____ Home Phone: _____
Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email Address: _____

RESPONSIBLE PARTY INFORMATION (if applicable)

Mother's Name: _____ Dental Insurance Covering Orthodontics? ☐ Yes ☐ No
Last First

Home Address: _____ Home Phone: _____
Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email Address: _____

Father's Name: _____ Dental Insurance Covering Orthodontics? ☐ Yes ☐ No
Last First Initial

Home Address: _____ Home Phone: _____
Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email Address: _____

Person Responsible for decisions regarding treatment and Account: _____ Number of Children in Family: _____

Patient's Family Dentist: _____ Phone: _____

Patient's Family Physician: _____ Phone: _____

Whom may we thank for referring you to our office: _____ School: _____

Medical History

Yes	No	
☐	☐	Being treated for any medical or heart conditions? If yes, describe: _____
☐	☐	Currently taking any prescription or non-prescription medications? If yes, describe: _____
☐	☐	Allergies? If yes, describe: _____
☐	☐	Previous hospitalizations or undergone any type or surgery? _____
☐	☐	Smoking or use of any tobacco products? If yes, how much? _____
☐	☐	For females, are you pregnant, or suspect that you might be? Anticipated due date: _____

Please list any other information about the medical history: _____

_____

Dental History

Yes	No	
☐	☐	Currently experiencing any dental pain? If yes, describe: _____
☐	☐	Any permanent teeth removed, including wisdom teeth? How many? _____
☐	☐	Previous orthodontic treatment or exam? If yes, when? _____
☐	☐	Any injuries to the face, teeth or mouth? If yes, describe: _____
☐	☐	Currently or history of soreness, tightness or pain in the muscles around the jaws and face, neck or pain opening and closing? _____
☐	☐	Frequent snoring and/or sleep apnea or predominantly breathing through the mouth? _____
☐	☐	Any habits? Previous or present thumb / finger / tongue sucking or other oral habit? If Yes, until what age? _____

Any other information you can give us is definitely appreciated. The more we know about each person, the more help we can give in managing the orthodontic treatment, both at home and in the clinic. *Also, please include any special interests or hobbies*:

_____

_____

By sharing your email with Clearly Orthodontics you agree to receive emails from us regarding appointments, contests/promotions and educational information and understand that you can opt out at any time your email and personal information will not be shared with 3rd parties at any time.

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, social media, research, education or publication in professional journals.

I consent to communicate electronically, and receive health and treatment information specific to my care. This electronic communication may not be secure.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

I have reviewed your office privacy policy, and I consent to your collection of any and all personal information about me including my personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relation to, your dental practice, Clearly Orthodontics*. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Profession, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer, other payment organizations who may be responsible for payment of all or a part of any treatment or service that you provide.*

_____ _____

Signature of Patient, Parent or Guardian **Date**