Patient Name: _____

Birth date: _____

Emergency Contact: _____

Phone: _____

CANYON ORTHODONTICS

Referred By: □DOCTOR_____ □ FRIEND/FAMILY_____ □ STAFF □ INSURANCE □ GOOGLE □ YAHOO □ MSN □ YELLOWPAGES.COM □ YELLOWPAGES □ YELLOWBOOK.COM □ SELF / WALK-IN □ OTHER WEBSITE _____ □ MONEY MAILER □ SUPER COUPS

Patient Medical History

Medical Physician:_____ Office Phone:_____Date of Last Exam:_____

	Yes	No
1.Are you under medical treatment now!	☐	☐
2.Have you ever been hospitalized for any surgical operation or serious illness within the **last 5 years**? If yes, please explain_____	☐	☐
3.Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?_____	☐	☐
4.Have you ever taken Phen-Fen/Redux?	☐	☐
5.Do you use tobacco?	☐	☐
6.Do you use controlled substances?	☐	☐
7.Are you wearing contact lenses?	☐	☐

9.Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. Novacaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. Nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐

10.Women Only:	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

8.Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implants	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other_____	☐	☐

Patient Dental History

Dentist:_____ Office Phone:_____Date of Last Exam:_____

	Yes	No
1.Do your gum bleed while brushing or flossing?	☐	☐
2.Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.Do you feel pain to any of your teeth?	☐	☐
5.Do you have any sores or lumps in or near your mouth?	☐	☐
6.Have you ever had traumatic incident involving your teeth?	☐	☐
7.Summarize your history of dental treatment:_____		

	Yes	No
8.Have you had any orthodontic treatment?	☐	☐
9.Do you like your smile?	☐	☐

10.Chief orthodontic complain_____

11.Why are you seeking orthodontic care now?_____

12.What do you expect from orthodontic treatment?_____

Hobbies/Interests_____

Favorite Sports_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ **Date**_____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____