PATIENT INFORMATION SHEET – ADULT

Patients Name: _____ Sex at birth**: M / F** Gender Identity: _____

Preferred Name: _____ Patient's Birthdate: _____/____/_____ Age: _____

Pronouns: _____ month / day / year

Address: _____(please include postal code)

Home Phone #: (____) _____-_____ Cell Phone #: (____) _____-_____ Carrier (ex. Rogers, Telus) _____

Email address: _____

We send email/text messages reminding you of your appointments. Please indicate the main cell phone (and carrier) and email address for your reminders.

Cell Phone: _____ Carrier (ex. Rogers, Telus) _____

Email Address: _____

Is there anyone else who will be financially responsible for your treatment? Yes / No

If yes, please provide their information below:

Name: _____ Relationship to patient: _____

Address same as patients above? Yes / No If No: _____

Cell Phone #: (____) _____ - _____ Carrier (ex. Rogers, Telus)_____ Home Phone #: (____) _____ - _____

Work Phone #: (____) _____- _____ Email Address: _____

We would like to call your insurance company prior to your appointment to provide you with the most accurate and up-to-date information possible.

Do You Have Dental Insurance? Yes / No

Primary Insurance

Name of Subscriber: _____ Date of Birth: _____

Insurance Company: _____ Group/Policy#: _____ Certificate/ID #: _____

Secondary Insurance

Name of Subscriber: _____ Date of Birth: _____

Insurance Company: _____ Group/Policy#: _____ Certificate/ID #: _____

How did you hear about our office? (please circle all that apply) Friend or Family (Name: _____)

Google	Social Media (Facebook, Instagram, etc)	Internet Search	Dentist Referral
Advertisement	Doctor Locator/Invisalign website	Doctor Locator/Damon Website	Other

Medical History

Do you have allergies? Yes / No If yes, what type? _____

Is an Epi Pen required? Y N

Do you have any conditions that affect the immune system (AIDS, HIV, Leukemia)? Y N

Do you bruise easily after injury? Y N

Do you experience prolonged bleeding after injury? Y N

Have you ever had?

Surgery with general anesthetic	Y	N	If yes, what type? _____		
Rheumatic Fever	Y	N	Diabetes	Y	N
Chronic kidney problems	Y	N	Heart problems	Y	N
Lung problems	Y	N	Liver problems	Y	N
Epilepsy	Y	N	Cerebral palsy	Y	N
Abnormal bleeding problems	Y	N	Prosthetic joint	Y	N
Bronchitis	Y	N	Head/Ear aches	Y	N

Please list any medications used regularly: _____

Any other medical information / dental related concerns you would like us to know about? _____

_____

Dental History

What are the main concerns regarding your teeth? _____

Who is your family dentist? _____

Do you:

Want orthodontic treatment:	Y	N			
See your general dentist regularly?	Y	N	Last visit: _____		
Smoke or chew tobacco?	Y	N			
Grind your teeth at night?	Y	N	If yes, do you wear a mouthguard?	Y	N

Have you:

Ever had previous orthodontic consultation/treatment?	Y	N
Ever had problems with sore gums?	Y	N
Ever seen a periodontist regarding gum health?	Y	N
Ever receive a severe blow to the teeth or jaws?	Y	N

I, _____, give permission for Dr Felty, Dr. Thong (and/or staff) to report any findings to my dentist or any other dental professional as they deem necessary. I understand that imaging can be forwarded directly to dental professionals at no charge, upon request. If a copy is desired by the patient, a fee will be incurred.

Signature: _____ Date: _____