PATIENT INFORMATION SHEET-YOUTH

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

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

Pronouns: _____ month / day / year

Patient's Address: _____

Patient's Home Phone #: (_____) _____ -_____

Patient's Cell Phone #: (_____) _____- _____ Carrier (ex. Rogers, Telus): _____

Patient's E-mail address: _____ School: _____

We send an email / text message reminding you of your appointment. Please indicate the main cell phone (with carrier) and email address for your reminders

Cell phone #: _____Carrier (ex. Rogers, Telus): _____

Email address : _____

For monitoring purposes, are there any siblings that may require orthodontic treatment now or in the future?

Sibling Name: _____ Birthdate: _____/_____/_____ Same address: Y / N Gender M / F / Oth

Sibling Name: _____ Birthdate: _____/_____/_____ Same address: Y / N Gender M / F / Oth

Sibling Name: _____ Birthdate: _____/_____/_____ Same address: Y / N Gender M / F / Oth

Name of Primary caregiver: _____ Circle one: Mother, Father, Step Parent, Other

Address same as patient's above? Y / N If no: _____

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

Work Phone #: (____) _____-_____ E-mail address: _____

Name of Secondary caregiver: _____ Circle one: Mother, Father, Step Parent, Other

Address same as patient's above? Y / N If no: _____

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

Work Phone #: (____) _____-_____ E-mail address: _____

Name of additional caregiver: _____ Circle one: Mother, father, Step Parent, Other

Address same as patient's above? Y / N If no: _____

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

Work Phone #: (____) _____-_____ E-mail address: _____

Medical History

Does the patient:

Have allergies? Yes / No If yes, what type? _____

Is an EpiPen required?	Y	N
Have any conditions that affect the immune system (AIDS, HIV, Leukemia)?	Y	N
Bruise easily after injury?	Y	N
Experience prolonged bleeding after injury?	Y	N

Has the patient 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 the patient's teeth? _____

_____

Who is your family dentist? _____

Does the patient:

Want orthodontic treatment?	Y	N			
Brush their teeth daily?	Y	N	How often: _____		
See a general dentist regularly?	Y	N	Last visit: _____		
Plays a musical air instrument?	Y	N	What type: _____		

Have the following habits?

Thumb sucking	Y	N
Grinding teeth at night	Y	N
Nail biting	Y	N
Mouth breathing (ex. Mouth open when reading/watching tv)	Y	N
Snoring	Y	N

Has the patient:

Ever had previous orthodontic consultations / treatment?	Y	N	
Ever had problems with sore gums?	Y	N	
Ever receive a severe blow to the teeth or jaws?	Y	N	
Ever had speech therapy?	Y	N	If yes, how old was patient? _____

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 Other _____

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 Policy

Name of Subscriber _____ Date of Birth _____

Name of Insurance _____ Group# _____ Certificate/ID #: _____

Secondary Insurance Policy

Name of Subscriber _____ Date of Birth _____

Name of Insurance _____ Group# _____ Certificate/ID #: _____

I, _____ (circle one: Mother, Father, Patient, Guardian), give permission to allow 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: _____