PATIENT INFORMATION SHEET – ADULT

Patient's Name:		Sex at birth: M / F	Gender Identity:			
Preferred Name:	Patient's B	irthdate:/	/ Age:			
Pronouns:		month / day / y	ear			
Address:			(please include postal co	ode)		
Home Phone #: ()	Cell Phone #: () _	Carrier	(ex. Rogers, Telus)			
Email address:						
We send email/text mand email address for	nessages reminding you of your appoing your reminders.	ntments. Please indica	ate the main cell phone (and cari	rier)		
Cell Phone:		Carrier (ex. Rog	ers, Telus)			
Email Address:						
Is there anyone else w	ho will be financially responsible for y	our treatment? Yes	/ No			
If yes, please provide t	their information below:					
Name:	Relatio	nship to patient:				
Address same as patie	nts above? Yes / No If No:					
Cell Phone #: () _	Carrier (ex. Rogers, Telu	ıs) Ho	me Phone #: ()			
Work Phone #: ()	Email Address:					
We would like to call y up-to-date informatio	your insurance company prior to your on possible.	appointment to provi	de you with the most accurate a	nd		
Do You Have Dental Ir	nsurance? Yes / No					
Primary Insurance						
Name of Subscriber: _		Date of Birth:				
Insurance Company: _	Group/Po	olicy#:	Certificate/ID #:			
Secondary Insurance						
Name of Subscriber: _		Date of Birth:				
Insurance Company: _	Group/Pc	olicy#:	Certificate/ID #:	_ Certificate/ID #:		
How did you hear about	t 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/Dar	non Website Other			

<u>Medical History</u>								
Do you have allergies? Yes / No	If yes, w	hat typ	e?			<u> </u>		
Is an Epi Pen required?				Υ	N			
Do you have any conditions that affect the immune system (AIDS, HIV, Leukemia)?					N			
Do you bruise easily after injury?				Υ	N			
Do you experience prolonged bleeding afte	r injury?			Υ	N			
Have you ever had?								
Surgery with general anesthetic	Υ	N	If yes, what type?					
Rheumatic Fever	Υ	N	Diabetes	Υ	N			
Chronic kidney problems	Υ	N	Heart problems	Υ	N			
Lung problems	Υ	N	Liver problems	Υ	N			
Epilepsy	Υ	N	Cerebral palsy	Υ	N			
Abnormal bleeding problems	Υ	N	Prosthetic joint	Υ	N			
Bronchitis	Υ	N	Head/Ear aches	Υ	N			
Please list any medications used regularly:								
Dental History What are the main concerns regarding your	teeth?							
Who is your family dentist?								
Do you:								
Want orthodontic treatment:	Υ	N						
See your general dentist regularly?	Υ	N	Last visit:					
Smoke or chew tobacco?	Υ	N						
Grind your teeth at night?	Υ	N	If yes, do you wear a mo	outhguard?		Υ	N	
Have you:								
Ever had previous orthodontic consultation/treatment?		Υ	N					
Ever had problems with sore gums?		Υ	N					
Ever seen a periodontist regarding gum hea	lth?	Υ	N					
Ever receive a severe blow to the teeth or ja	aws?	Υ	N					
I,to my dentist or any other dental profe	ssional as th	ey deei	m necessary. I understan	d that ima	ging can b	staff) to be forward	report any find ded directly to	ings denta
professionals at no charge, upon reque				/III be incu	rred.			
Signature:			Date:					

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.