

PATIENT INFORMATION SHEET – ADULT

Patient's 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 text / email reminders only for appointments. Please indicate the main cell phone (and carrier) and email. By providing a cell number, I agree to receive automated appointment and general office messages to the number provided. Rogers, Bell, and Virgin carriers will not be able to receive text reminders due to their carrier restrictions.

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:

	Yes	No
Have allergies?	☐	☐
If yes, what type? _____		
Is an EpiPen required?	☐	☐
Have any conditions that affect the immune system (AIDS, HIV, Leukemia)?	☐	☐
Bruise easily after injury?	☐	☐
Experience prolonged bleeding after injury?	☐	☐
Surgery with general anesthetic?	☐	☐
If yes, what type of surgery? _____		
History of osteoporosis/ Paget's Disease?	☐	☐
If yes, any medications past or present for treatment? _____		

	Diagnosed	Awaiting Assessment	Suspected	No History
Diabetes	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐
Chronic kidney problems	☐	☐	☐	☐
Heart problems	☐	☐	☐	☐
Lung/Airway Issues	☐	☐	☐	☐
Liver problems	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐
Abnormal bleeding problems	☐	☐	☐	☐
Prosthetic joint	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐
Head/ear aches	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Adhd	☐	☐	☐	☐
Autism (ASD)	☐	☐	☐	☐

Please list any medications used regularly: _____

Any other medical information/ diagnosis: _____

Dental History

What are the main concerns regarding your teeth? _____

Who is your family dentist? _____

Do you :

Yes No

Want orthodontic treatment?

☐☐

Unsure

Brush your teeth daily?

☐☐

How often: _____

See a general dentist regularly?

☐☐

Last visit: _____

Play a musical air instrument?

☐☐

What type: _____

Have the following habits?

Yes

No

Previous (note when stopped)

Thumb sucking

☐☐☐

Grinding teeth at night

☐☐☐

Nail biting

☐☐☐

Mouth breathing (ex. Mouth open when reading/watching tv)

☐☐☐

Snoring

☐☐☐

Have you:

Yes

No

Ever had previous orthodontic consultations / treatment?

☐☐

Ever had problems with sore gums?

☐☐

Ever receive a severe blow to the teeth or jaws?

☐☐

Ever had speech therapy?

☐☐

If yes, how old? _____

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: _____

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.