

PATIENT INFORMATION SHEET-YOUTH

Patient's Name: _____ Sex at birth: **M / F** Gender Identity: _____

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

Pronouns: _____ month / day / year

Patient's Address: _____

Home Phone #: (____) ____ - ____

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

Email address: _____ School: _____

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 : _____

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 the 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 the 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 the patient's above? Y / N If no: _____

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

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

****Treatment and financial information will only be released to the names provided on this form**

Medical History

<u>Does the patient:</u>	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 rate your child on the following scales:

Child's ability to complete an appointment independently without additional assistance (i.e. parent present):

1 (not able) 2 3 4 5 (has previously completed appts on their own with no issue)

Does your child have any sensory concerns:

1 (not able to tolerate certain tastes, feelings, sounds) 2 3 4 5 (no sensory concerns)

Rate your child's general level of anxiety:

1 (generally anxious in various settings) 2 3 4 5 (no anxiety/ concerns)

Please list any medications used regularly: _____

Any other medical information/ diagnosis: _____

Dental History

What are the main concerns regarding the patient's teeth? _____

Who is your family dentist? _____

Does the patient:

Yes No

Want orthodontic treatment?

☐☐

Unsure

Brush their teeth daily?

☐☐

How often: _____

See a general dentist regularly?

☐☐

Last visit: _____

Plays 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

☐☐☐

Has the patient:

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 was the pt? _____

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: _____

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.