PITT MEADOWS | ORTHODONTICS

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# NEW PATIENT INFORMATION FORM

Date: mm / dd / yyyy

First Name: _____ Home Phone #: _____

Last Name: _____ Cell Phone #: _____

Address: _____ Business Phone #: _____

City and Prov.: _____ Dentist Name: _____

Postal Code: _____ Dental Ins. Comp: _____

Date of Birth: _____ Policy or ID #: _____

Group or Certif. #: _____

Email: _____ Do you prefer Email as a paper delivery method? Yes No

## MEDICAL HISTORY

| | | Yes | No |
|---|---|---|---|
| 1. | Have you ever had a serious illness or are you under the care of a physician now? | | |
| 2. | Are you taking any medication or drugs? If yes, please include the name(s): | | |
| 3. | Have you been warned against taking any medicines or chemicals? | | |
| 4. | Have you an allergy, asthma, hives, or skin rash? If yes, please write them down: | | |
| 5. | Do you bruise easily or have prolonged bleeding? | | |
| 6. | Have you ever had an injury, surgery, or X-ray therapy on your head or jaws? | | |
| 7. | Do you have a tendency to faint? | | |
| 8. | Do you have any artificial joints, heart valves, pacemaker, or prosthetic? | | |
| 9. | Have you ever had any indications of AIDS HIV injection, or other immune disorders? | | |
| 10. | Have you ever have any of the following conditions? (Please check) | | |

- ☐ Hepatitis
- ☐ Jaundice
- ☐ Diabetes
- ☐ Stroke Epilepsy
- ☐ Tuberculosis
- ☐ Any Lung Disease
- ☐ Hemophilia
- ☐ Rheumatic Fever
- ☐ Emphysema
- ☐ Arthritis
- ☐ Stomach Problems
- ☐ Sinus Problems

- [ ] Venereal Disease
- [ ] Cancer
- [ ] Kidney Disease
- [ ] High Blood Pressure
- [ ] Mental or Nervous Disorder
- [ ] Heart Murmur/Heart Disease/Heart Attack

11. Have you ever experienced any unusual reaction to any of the following? (Please check)

- [ ] Penicillin
- [ ] Sulfonamide (Sulfa)
- [ ] Barbiturates
- [ ] Local Anesthesia
- [ ] Aspirin
- [ ] Iodine
- [ ] Codeine
- [ ] Any other medicine

| | Yes | No |
|---|---|---|
| 12. Do you have any health concern that the doctor should know about? . . . . . | ☐ | ☐ |

13. WOMEN only. Are you pregnant?
    If so, what is your due date?

Parent/Guardian: _____

The legally authorized surrogate decision maker, do hereby request treatment at Pitt Meadows Orthodontics for:

Patient Name: _____

I authorize Pitt Meadows Orthodontics team to carry out on my dependent/myself examination and such investigations, treatment or procedures, including the administration of anesthetics, and the use of radiographs (x-rays) as may be recommended for the treatment. I have read and understand the above. I consent to whatever dental/orthodontic procedure that are necessary for the treatment of my case.

Referred by: _____

Signature: _____