ANNEX

ORTHODONTICS PERIODONTICS

# INSTRUCTIONS

1. Complete the form below to the best of your ability.

2. Once completed, click the “File” menu option at the top of the screen and “Save” it.

3. Attach the completed PDF form to an email and send it to: info@annexorthoperio.com.

**THANK YOU**

ORTHODONTICS PERIODONTICS

## Adult Patient Personal Information

Consultation Date: ____________________________________ Date of Birth: __________________________________

Name:______________________________________________ Salutation: Dr/Mr/Mrs/Ms/Miss Sex: ☐Female ☐Male

Address: ___________________________________________ Home Phone Number: ________________________

City:_________________________ Province:_______________ Work Phone Number: ________________________

Postal Code: ________________________________________ Cell Phone Number: __________________________

Occupation: _________________________________________ Email Address: _______________________________

Can we e-mail you information specific to your diagnosis and treatment plan? Yes ☐ No ☐

Would you prefer to receive appointment confirmations by phone or by e-mail? __________________________________

Marital Status (Check One): ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's name (if applicable):______________________________

Emergency Contact: ___________________________________ Emergency Phone Number: ______________________

## Dental History

Who is your family Dentist?_____________________________ Date of last dental checkup:______________________

Have you seen an Orthodontist before? __________________ If yes, when most recently? ______________________

Indicate any history of (check all that apply):

☐ Teeth extracted ☐ Thumb/finger sucking ☐ Tongue and/or swallowing problems

☐ Injury to face or teeth ☐ Speech/articulation problems ☐ Grinding and/or clenching teeth

☐ Jaw joint problems ☐ Tonsils removed ☐ Mouth breathing preferred to nose breathing

☐ Sleep apnea or sleep disturbances

## Medical History

Family Physician: ______________________________________ Date of last check up:__________________________

Are you currently under medical care? ____________________ If yes, explain:____________________________________

Do you have any drug allergies? __________________________ If yes, explain:____________________________________

Are you taking any medications or supplements? ______________________________________________________________

Indicate any history of (check all that apply):

☐ Epilepsy or seizures ☐ Hepatitis ☐ Diabetes ☐ Nickel/metal allergy

☐ Hereditary problems ☐ Heart murmur ☐ Anemia ☐ Latex allergy

☐ Asthma ☐ Heart problems ☐ Prolonged bleeding ☐ Smoking (quantity__________)

☐ Headaches ☐ H.I.V./A.I.D.S. ☐ Surgery ☐ Other:____________________

Who may we thank for referring you? ____________________ Reason for today's visit: __________________________

Yes No

☐ ☐ I consent to having Dr. Heckler do a clinical orthodontic examination with diagnostic imaging.

☐ ☐ I consent to the discretionary and anonymous use of clinical photos and x-rays for Dr. Heckler's educational/teaching purposes.

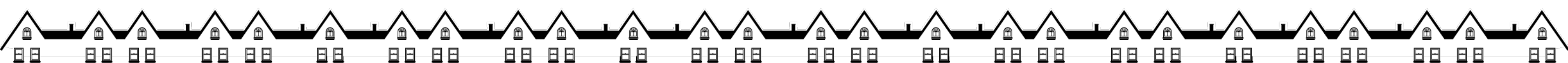
☐ ☐ I consent to having reviewed Dr. Heckler's privacy policy (see over, please)

☐ ☐ I consent to receive email communication from your office.

_______________________________________________ _______________________________________________

**Patient signature** **Chart Number**





ANNEX

**The Personal Information Protection and Electronic Document Act**

The Canadian government now requires that we have your permission to collect your personal dental and medical information. This information will be used only to assess your oral health needs and advise you of treatment options. It will allow us to maintain communication with you and to communicate with your dentist, physician, and other health providers as well as provide insurance claim forms and treatment estimates. As well, your personal information can be used for teaching and demonstrating purposes on an anonymous and confidential basis, to process payments, and to collect unpaid accounts. All this information will be kept private and confidential, and it will be accessible to you upon request.

I give permission to Dr. Andrea Heckler to collect, use and disclose personal information about
______________________________ for the purposes indicated.
(patient name)

_______________________________
Signature

_______________________________
Print name

_______________________________
Date

_______________________________
Signature of witness

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