Patient Registration Form

General Info

Last Name: _____ First Name: _____ Preferred Name: _____

Birthdate: (yy/mm/dd) _____ Age: _____ ❑ Male ❑ Female

Home Address: _____ City : _____ Prov. _____ Postal Code: _____

Phone (H): _____ Phone (W): _____ Phone (C): _____

Referred by: _____ Dentist Name: _____ Dentist's Tel: _____

Gov't Sponsored Plan? ❑ Yes ❑ No *If yes, what type?* _____ CareCard: _____

Family Status *(Please fill out this section only if patient is a child)*

Parents:	Mother's Name:	Place of Employment:
	Birthdate: (yy/mm/dd)	Work Telephone:
	Father's Name:	Place of Employment:
	Birthdate: (yy/mm/dd)	Work Telephone:
Siblings:	Brothers' Names & Ages	
	Sisters' Names & Ages:	

Has any other family member been treated at this office? ❑ Yes ❑ No Names: _____

Patient Living With: ❑ Mother ❑ Father ❑ Other _____ Patient Adopted: ❑ Yes ❑ No

Patient's School: _____

Person to contact in case of Emergency: Telephone:

Insurance Information – Please Complete

Name of Insured:	Name of Insured:
Birth date: (yy/mm/dd):	Birth date: (yy/mm/dd):
Insurance Company #1:	Insurance Company #1:
Plan / Policy Number:	Plan / Policy Number:
Certificate / ID Number:	Certificate / ID Number:
Division Number:	Division Number:
Patient's Dependent #:	Patient's Dependent #:
Employer:	Employer:
Relation:	Relation:

Personal Information Protection Act Consent Box

I consent that any information given to Monarch Orthodontic Centre can be:

❑ Yes ❑ No Communicated with other health professionals, such as dentists, doctors etc. on you and/or your child's behalf.

❑ Yes ❑ No Communicated with insurance providers on your behalf to facilitate you and/or your child's treatment if applicable.

Financial Information

Name of Person responsible for account if treatment is started: _____ Phone #: _____

Address: Relation:

Signature: _____ Date: _____

Medical / Dental History Form

Last Name: _____ First name: _____

Family Doctor: _____ Telephone: _____

Address:

Medical Information

1. Does patient have any birth defects or disabilities? *If yes, what?* ❑ Yes ❑ No
   _____
2. Emotional problems *If yes, what?* ❑ Yes ❑ No
   _____
3. *Heart disease, murmur or rheumatic fever If yes, has your doctor recommended antibiotics before dental work?* ❑ Yes ❑ No
   _____
4. Allergies to the following:
   - Aspirin or pain medication ❑ Yes ❑ No
   - Antibiotics ❑ Yes ❑ No
   - Dental anesthetics ❑ Yes ❑ No
   - Other ❑ Yes ❑ No

   If yes to any of the above, what?
   _____
5. Major illness, surgery or conditions? *If yes, what?* ❑ Yes ❑ No
   _____
6. Taking any drugs? (prescription or non-prescription) *If yes, what?* ❑ Yes ❑ No
   _____
7. High or low blood pressure ❑ Yes ❑ No
8. Sinus problems ❑ Yes ❑ No
9. Herpes or cold sores ❑ Yes ❑ No
10. Immunological deficiency disease (i.e. AIDS, leukemia) ❑ Yes ❑ No
11. Diabetes ❑ Yes ❑ No
12. Kidney disease ❑ Yes ❑ No
13. Liver disease (hepatitis or jaundice) ❑ Yes ❑ No
14. Cancer, tumours, other growths ❑ Yes ❑ No
15. Radiation or chemotherapy ❑ Yes ❑ No
16. Thyroid problems ❑ Yes ❑ No
17. Arthritis ❑ Yes ❑ No
18. Lung disease (TB, asthma or persistent cough) ❑ Yes ❑ No
19. Epilepsy, seizures or fainting spells ❑ Yes ❑ No
20. Sore throat, tonsillitis, earaches ❑ Yes ❑ No
21. Smoking or chewing tobacco ❑ Yes ❑ No
22. Abnormal bleeding or blood disorders *If yes, what?* ❑ Yes ❑ No
    _____
23. **Females**-Are you pregnant? ❑ Yes ❑ No

Dental Information

Is there a history of thumb sucking? ❑ Yes ❑ No

Is the thumb or finger sucking still present? ❑ Yes ❑ No

Has patient ever had any injury to the mouth or teeth? ❑ Yes ❑ No

When was your last dental check-up and cleaning? _____

Any cavities or gum problems? _____

Consulted an orthodontist previously? _____

Had previous orthodontic treatment? _____

Any negative experiences with dentists or doctors? _____

Is there a HISTORY of:

Clenching teeth or grinding ❑ Yes ❑ No

Muscular soreness around head and neck ❑ Yes ❑ No

Headaches (more than normal) ❑ Yes ❑ No

Jaw joint soreness or clicking ❑ Yes ❑ No

Patient Signature or
If patient under 18 years old,
Signature of Guardian: _____ Date: _____