WELCOME TO OUR OFFICE!

For your benefit, please have this form completed and bring it with you to your first visit.

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____

POSTAL CODE: _____ PHONE #: _____ WORK#: _____

☐ Male ☐ Female REFERRED BY: _____ DENTIST: _____

INSURANCE: ☐ Yes ☐ No ☐ Dual

* EMAIL ADDRESS: _____

Is any family member a patient at our office? ☐ No ☐ Yes: _____

Reason for seeking treatment: _____

MEDICAL HISTORY:

Medical Doctor: _____

Please check any of the following conditions which apply to you:

☐ Severe Headaches	☐ Sore Throat	☐ Bleeding Gums	☐ Joint Pain
☐ Heart Disease	☐ Convulsions	☐ High Blood Pressure	☐ Poor Vision
☐ Fainting Spells	☐ Chest Pains	☐ Ease of Bruising	☐ Sinus Condition
☐ Ulcers	☐ Tooth Ache	☐ Dizzy Spells	☐ Shortness of Breath

Please check any of the following illnesses you have ever had:

☐ Rheumatic Fever	☐ Asthma	☐ Angina	☐ Psychiatric Care
☐ Hepatitis	☐ TB	☐ Heart Disease	☐ Autism Spectrum
☐ Jaundice	☐ Scarlet Fever	☐ Thyroid Problem	☐ Emotional Disturbances
☐ Diabetes	☐ Mononucleosis	☐ Malignant Hyperthermia	☐ Learning Difficulties

Are you suffering from any illness? _____

Please note any previous hospitalizations and surgeries, and the year: _____

_____

List any allergies to medicine or food: _____

List present medication: _____

How would you describe your health? _____

Is there anything in your medical history of which the dentist should be aware? _____

_____

(Women:) Are you pregnant now? _____

DENTAL HISTORY:

1. When was your last dental visit? _____
2. What was done at that visit? _____
3. Have you ever sought orthodontic consultation or had orthodontic treatment previously? _____

_____

4. Do you have difficulty chewing? _____
5. Are you conscious of any pain in your jaw muscle? _____

DATE: _____ **SIGNATURE**: _____

VOTH • LALANI • PARETE - ORTHODONTISTS
101 • 7150 Hawthorne Drive. • Windsor, ON N8T 3N3 • 519-948-2471 • FAX: 519-974-2951 •www.vlportho.com