VILLAGE ORTHODONTICS

...for your **smile.**

Date: _____

CONSULTATION QUESTIONNAIRE

Patient (please print)

Name _____ Age ___ Male ___ Female ___ Birthdate _____ (M D Y)

Mailing Address _____ Unit # _____ Postal Code _____

Home # _____ Cell # _____ Email _____

Dentist _____ Dental Insurance ☐ **Yes** ☐ **No**

Responsible Party (Parent/Guardian)

Name _____ Birthdate _____ (M D Y) Relationship (to patient) _____

Mailing Address _____ Unit # _____

Employer _____ Business # _____ Email _____

Responsible Party (Parent/Guardian)

Name _____ Birthdate _____ (M D Y) Relationship (to patient) _____

Mailing Address _____ Unit # _____

Employer _____ Business # _____ Email _____

Whom may we thank for referring you to our office?

_____ Dentist _____ Specialist Name _____

_____ Patient _____ Other Name _____

In order to provide the best possible care for our patients, we would appreciate your accurate completion of the following questionnaire.

Yes	No	Unsure	Medical History
☐	☐	☐	Is the patient in good general health? When was the last visit to a physician? _____ What was the reason for your last medical visit? _____
☐	☐	☐	Has there been a change in general health in the past year?
☐	☐	☐	Is there currently treatment ongoing for any medical condition or has treatment been provided within the last year? Please provide reason _____
☐	☐	☐	Is there a history of having been hospitalized for any serious conditions or operations? Please specify _____
☐	☐	☐	Is there currently a need for medications or non-prescription drugs of any kind? If yes, please specify _____
☐	☐	☐	Is there a history of any allergies? Please specify _____
☐	☐	☐	Has there ever been a history of peculiar or adverse reactions to any medications or injections? (i.e. penicillin, aspirin, dental anaesthetics “dental freezing”)
☐	☐	☐	Is there a tendency to breathe through the mouth?
☐	☐	☐	Have the tonsils and/or the adenoids ever been removed?
☐	☐	☐	Is there a history of heart or blood pressure problems?
☐	☐	☐	Is there a history of prosthetic cardiac valve, previous infective endocarditis, congenital heart disease (CHD), cardiac transplantation or cardiac valvulopathy?
☐	☐	☐	Has there ever been a history of rheumatic fever?
☐	☐	☐	Has there ever been a history of jaundice, hepatitis or liver disease or knowledge of contact with a person with any of these conditions?
☐	☐	☐	Has the patient ever been advised not to give blood?

Yes	No	Unsure	Medical History (continued)
☐	☐	☐	Is there a history of conditions that could affect the immune system? (i.e. AIDS, HIV Positive, leukemia, etc.)
☐	☐	☐	Is there a tendency to bruise easily or to bleed for a prolonged period of time after being cut?
☐	☐	☐	Is there a history of any of the following? Please tick only those that apply:
			_____chest pain_____heart attack_____stroke_____prosthetic joint_____bronchitis
			_____emphysema_____asthma_____tuberculosis _____ epilepsy_____stomach ulcers
			_____drug/alcohol dependency_____arthritis_____diabetes_____kidney disease
☐	☐	☐	Does the patient currently smoke or chew tobacco?
☐	☐	☐	For women only – are you pregnant? And if so, what is the expected delivery date? _____

Yes	No	Unsure	Dental History
☐	☐	☐	Has the patient been seeing a dentist regularly?
			When was the last dental visit? _____
			When were the last dental x-rays taken? _____
☐	☐	☐	Do any of the teeth ache?
☐	☐	☐	Has the patient ever been advised to take antibiotics before dental appointments?
☐	☐	☐	Has the patient had implant surgery or jaw joint surgery?
☐	☐	☐	If yes, please indicate the surgeon's name and date of surgery: _____
			_____
☐	☐	☐	Is the patient being followed up by any other dental specialist?
☐	☐	☐	If yes, please indicate the specialist's name and specialty: _____

Please list anything else not mentioned above, regarding the patient's past dental history.

_____

_____

Yes	No	Unsure	Orthodontic History
☐	☐	☐	Has there been any previous orthodontic treatment?
☐	☐	☐	Have there been any previous orthodontic consultations?
☐	☐	☐	Is there a history in your family of poorly positioned teeth?
☐	☐	☐	Is there a history in your family of jaw size discrepancies?
☐	☐	☐	Has any other family member had orthodontic treatment?
☐	☐	☐	Has there been a finger or thumb sucking habit – ongoing/in the past?
☐	☐	☐	Has the patient had any accidents involving the teeth/jaws/nose?
☐	☐	☐	Does the patient suffer from frequent headaches/earaches?
☐	☐	☐	Has the patient had any teeth extracted by the dentist?

Acknowledgment regarding Information Provided
By providing my email address I agree to receive email messages fro Village Orthodontics which may include appointment confirmations, newsletters, and upcoming events and important notifications. I can withdraw my consent at any time.

The Patient, or the Responsible Party on behalf of the Patient (the "undersigned"), certifies that the information provided in this Consultation Questionnaire is accurate and complete and no material information was knowingly omitted. Should there be any change in either the health status of the Patient or any other information the undersigned has provided the undersigned will advise this orthodontic office immediately. The privacy policy of this office complies with the *Personal Health Information Act* (Manitoba) and the standards of our regulatory body, the Manitoba Dental Association (the "**Association**"). The undersigned confirms being advised of the privacy policy of this office, and that the personal information of the Patient shall be collected, used and disclosed within the guideline of such privacy policy.

Information for our Patients
At Village Orthodontics, all professional orthodontic services are performed by licensed members of the Association (the "**Orthodontic Professionals**"), and all institutional health care services are performed independently by Murrell Technical Services, under the clinical supervision and control of Orthodontic Professionals, in a cost-sharing arrangement. Village Orthodontics and Murrell Technical Services are each independent corporations but for ease of administration they may render joint invoices for their respective services. One of our Orthodontic Professionals has a financial interest in Murrell Technical Services. By signing this form, the undersigned acknowledges and agrees that they have read and understood the information and disclosures set forth herein prior to nay professional services being provided to the Patient by Village Orthodontics.

_____ _____ _____
Date: *Signature* ☐ Patient ☐ Parent ☐ Guardian Print Name of ☐ Patient ☐ Parent ☐ Guardian

Reviewed by treating orthodontist: _____ Date: _____