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 _____ Dentist # _____ Physician _____

Responsible Party (Parent/Guardian)

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

Mailing Address _____ Unit # _____

Employer _____ Business # _____

Responsible Party (Parent/Guardian)

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

Mailing Address _____ Unit # _____

Employer _____ Business # _____

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?

Information for our Patients
At Village Orthodontics™, all professional orthodontic services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"), and all institutional orthodontic-related care services are performed independently by Murrell Technical Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Village Orthodontics™ and Murrell Technical Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Murrell Technical Services.

Privacy Act and Consent to Treatment
By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Village Orthodontics™; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Village Orthodontics™ to provide the services you are requesting.

Acknowledgement regarding Information Provided
I, the undersigned, certify that I have provided and accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Village Orthodontics™, Murrell Technical Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Village Orthodontics™ and Murrell Technical Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Village Orthodontics™ and Murrell Technical Services are relying upon the information which I have provided being accurate and complete.

_____ _____ _____

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

Reviewed by treating orthodontist: _____ Date: _____