Orthodontic
Information Form

Thank you for your cooperation.
The information on this form will be kept confidential.

PATIENT INFORMATION

Date:

Patient Name: _____ Birth date: _____ (month/day/year) Age: _____

Address: _____

City/Town: _____ Postal Code: _____

Phone: Home: _____ Cell/other: _____

How do you wish to be reminded of your appointments (check off all that apply)?

___ Email (parent/guardian) ___ Email (patient) ___Text (parent/guardian) ___Text (patient) ___ Phone

Email (parent/guardian): _____

Email (patient): _____

Cell number for text messages: _____

May we email your receipts and any further appointment information? ____Yes ____No

If patient is a minor, please give parent or guardian information:

Parent/guardian name: _____ Relationship: _____Work Number: _____

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May we contact you at work? ___ Yes ___ No

What are the patient's concerns regarding the teeth and jaws?

_____

_____

Whom may we thank for referring you to our office? _____

Medical History

Physician: _____

Last medical check-up: _____ Present health status: _____

Past severe illnesses? ___ Yes ___ No Past hospitalization? ___ Yes ___ No

Past facial trauma? ___ Yes ___ No Current medications? ___ Yes ___ No

Allergies (medications, latex, nickel, etc.)? ___ Yes ___ No

If yes to any of the above, please explain: _____

_____

Dental History

Dentist: _____

Last dental check-up: _____ How often do you go for dental check-ups? _____

Have the following ever been present?

Thumb or finger sucking? ___ Yes ___ No Tooth grinding/clenching? ___ Yes ___ No

Speech problem? ___ Yes ___ No Other jaw problems? ___ Yes ___ No

If yes to any of the above, please explain: _____

_____

FINANCIAL RESPONSIBILITY

Person financially responsible for the orthodontic treatment of _____ :
Patient Name

Name: _____ **Phone:** _____

Address: _____ **Postal Code:** _____

Do you have a dental plan covering orthodontic treatment? ___ Yes ___ No

_____
Signature of financially responsible party

Do you have supplementary coverage through Family Health Benefits? ____ Yes ____ No

Health services # _____

Do you have coverage through First Canadian Health? ____ Yes ____No

Client identification # _____

ACKNOWLEDGEMENT AND CONSENT

I, _____, acknowledge with Dr. Todd Jarotski's Orthodontic Office Privacy Policy and I understand my rights of privacy with respect to my personal information.

I further consent to the collection, use and disclosure of my personal information for the following services:

- To provide me with orthodontic services
- To maintain communications and provide me with information and follow up respecting my orthodontic care
- To obtain payment of my account
- For the uses, purposes and disclosures described in the Privacy Policy; and
- Other

_____

_____

RESTRICTED ACCESS
My personal information shall not be provided to the following individuals or organizations:

_____

_____

RESTRICTED INFORMATION
Personal information disclosed from personal information collected shall not include:

_____

_____

_____
Signature / Signature of parent if a minor

PRIVACY POLICY AVAILABLE UPON REQUEST