ANNEX

ORTHODONTICS PERIODONTICS

INSTRUCTIONS

1. Complete the form below to the best of your ability.

2. Once completed, click the “File” menu option at the top of the screen and “Save” it.

3. Attach the completed PDF form to an email and send it to: info@annexorthoperio.com.

THANK YOU

ANNEX

Child Patient Personal Information

Consultation Date: ______________________ Date of Birth (DD/MM/YEAR): ______________

Name: ______________________ Sex: ☐ Female ☐ Male

Address: ______________________ Home Phone Number: ______________

City: ____________ Province: __________ Cell Phone Number: ______________

Postal Code: ______________________ Email Address: ______________

Parent/Guardian Information

Title: (Dr/Ms/Mrs/Miss/Mr.): ______________ Title: (Dr/Ms/Mrs/Miss/Mr.): ______________

Parent's name: ______________ Parent's name: ______________

Address: ______________ Address: ______________

City: ______________ City: ______________

Postal Code: ______________ Postal Code: ______________

Home Phone Number: ______________ Home Phone Number: ______________

Work Phone Number: ______________ Work Phone Number: ______________

Cell Phone Number: ______________ Cell Phone Number: ______________

Email Address: ______________ Email Address: ______________

Person(s) responsible for financial obligation: ______________________

Marital Status (Check One): ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Can we e-mail you information specific to your child's diagnosis and treatment plan? Yes ☐ No ☐

Would you prefer to receive appointment confirmations by phone or by e-mail? ______________

Dental History

Who is your family Dentist? ______________ Date of last dental checkup: ______________

Have you seen an Orthodontist before? ______________ If yes, when most recently? ______________

Indicate any history of (check all that apply):

- ☐ Teeth extracted
- ☐ Thumb/finger sucking
- ☐ Tongue and/or swallowing problems
- ☐ Injury to face or teeth
- ☐ Speech/articulation problems
- ☐ Grinding and/or clenching teeth
- ☐ Jaw joint problems
- ☐ Tonsils removed
- ☐ Mouth breathing preferred to nose breathing
- ☐ Sleep apnea or sleep disturbances

Medical History

Family Physician: ______________ Date of last check up: ______________

Are you currently under medical care? ______________ If yes, explain: ______________

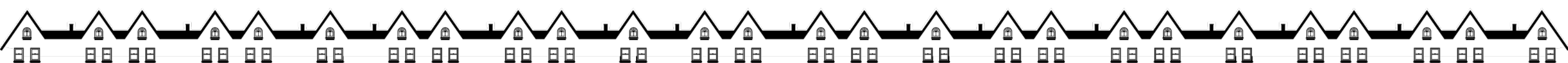
Do you have any drug allergies? ______________ If yes, explain: ______________

Are you taking any medications or supplements? ______________________

Indicate any history of (check all that apply):

- ☐ Epilepsy or seizures
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Nickel/metal allergy
- ☐ Hereditary problems
- ☐ Heart murmur
- ☐ Anemia
- ☐ Latex allergy
- ☐ Asthma
- ☐ Heart problems
- ☐ Prolonged bleeding
- ☐ Rheumatic fever
- ☐ Headaches
- ☐ H.I.V./A.I.D.S.
- ☐ Surgery
- ☐ Other: ______________

Please turn over



Who may we thank for referring you? ___________________ Reason for today's visit: _______________________

Yes	No	
☐	☐	I consent to having Dr. Heckler do a clinical orthodontic examination with diagnostic imaging.
☐	☐	I consent to the discretionary and anonymous use of clinical photos and x-rays for Dr. Heckler's educational/teaching purposes.
☐	☐	I consent to having reviewed Dr. Heckler's privacy policy (see below, please)
☐	☐	I consent to receive email communication from your office.

_______________________________   _______________________________

Parent/Guardian signature   **Chart Number**

The Personal Information Protection and Electronic Document Act

The Canadian government now requires that we have your permission to collect your personal dental and medical information. This information will be used only to assess your oral health needs and advise you of treatment options. It will allow us to maintain communication with you and to communicate with your dentist, physician, and other health providers as well as provide insurance claim forms and treatment estimates. As well, your personal information can be used for teaching and demonstrating purposes on an anonymous and confidential basis, to process payments, and to collect unpaid accounts. All this information will be kept private and confidential, and it will be accessible to you upon request.

I give permission to Dr. Andrea Heckler to collect, use and disclose personal information about _____________________________ for the purposes indicated.
(patient name)

____
Signature

____
Print name

____
Date

____
Signature of witness