Dr. Iris Kivity-Chandler
Orthodontist

PATIENT INFORMATION

Date:___________

Patient's Last Name:_______________ First Name:_________________

Birth Date:______________ Age:_____ Sex: Male___ Female___

Home Phone No.: _______________ Cell Phone and /or work No: _________________________

Patient's Address: ____

City:_____________________ Province:______________ Postal Code:_____________________

Mother's Name __________________________ Father's Name_________________________

Patient lives with: Mother ______ Father______ Both________

Mother or Father's address: (if different from Patient):____________________________________

City: ___________________ Province: __________________ Postal code: _________________

Phone No.: (If different from patient): _________________

Name of Patient's Dentist: ____________________________ Phone No.:___________________

Dentist's Address: ____

City: _______________ Province: ________________ Postal Code: _____________________

Date Last Seen: _____________ Reason: ____

Name of Patient's Physician: ___________________________ Phone No.: _________________

Date Last Seen: _____________ Reason: ____

Attends School At: ____ Grade: ______________

Musical Instruments Played: ____

Sports And/Or Hobbies: ____

No. of brothers and sisters: _____ Ages: _________________

Other family members treated here: _____________________________________

Patient's Birth Weight ____lbs. ___oz. Patient's Present Weight ____lbs. Height ____ft. ____in.

Who is financially responsible for this account? ____

Who suggested that your child might need orthodontic treatment? __________________________

Who referred you to our office? ____

WHAT IS THE CHIEF COMPLAINT THAT YOU ARE SEEKING TREATMENT FOR IN OUR OFFICE PLEASE

IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-9

	Recent	Chronic		Recent	Chronic
___ Headache pain	☐	☐	___ Kicking or jerking leg repeatedly	☐	☐
___ Ear pain	☐	☐	___ Swelling in ankles or feet	☐	☐
___Jaw pain	☐	☐	___ Morning hoarseness	☐	☐
___ Facial pain	☐	☐	___ Dry mouth upon waking	☐	☐
___Eye pain	☐	☐	___Fatigue	☐	☐
___Throat pain	☐	☐	___Difficulty falling asleep	☐	☐
___Neck pain	☐	☐	___Tossing and turning frequently	☐	☐
___Shoulder pain	☐	☐	___Repeated awakening	☐	☐
___Back pain	☐	☐	___Feeling unrefreshed in the morning	☐	☐
___Limited ability to open mouth	☐	☐	___Significant daytime drowsiness	☐	☐
___Jaw joint locking	☐	☐	___Frequent heavy snoring	☐	☐
___Jaw joint noises	☐	☐	___Affects sleep of others	☐	☐
___Ear congestion	☐	☐	___Gasping when waking	☐	☐
___ Sinus congestion	☐	☐	___Told that "I stop breathing" during sleep	☐	☐
___Dizziness	☐	☐	___Night-time choking spells	☐	☐
___Tinnitus (ringing in the ears)	☐	☐	___Unable to tolerate C-Pap	☐	☐
___Muscle twitching	☐	☐	___Tooth grinding	☐	☐
___Vision problems	☐	☐	___Teeth crowding	☐	☐

OTHER: ____

____

Do you have concerns in any of these areas: ___General Appearance ___Overbite ___Ability to Function ___Smile

Other Comments:____

Do any of the above complaints or concerns affect your daily life? ______________________________

What are the results you are seeking from treatment?______________________________

Patient Signature: ______________________ Date: ______________________

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction

☐ Anesthetics	☐ Codeine	☐ Penicillin
☐ Antibiotics	☐ Iodine	☐ Plastic
☐ Aspirin	☐ Latex	☐ Sedatives
☐ Barbituates	☐ Metals	☐ Sulfa

Other: ____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-conter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: ______________________________ **Date:** ______________

Parent/Guardian Signature (if patient is a minor): ______________________ **Date:** ______________

HEALTH AND MEDICAL HISTORY

☐Yes ☐No Are you currently pregnant?

☐Yes ☐No Have you sustained injury to: ☐Head ☐Neck ☐Face ☐Teeth ☐Other ____________

☐Yes ☐No Do you drink 4 or more cups of coffee per day? ☐Yes ☐No Do you smoke tobacco?

☐Yes ☐No Have you had prior orthodontic treatments. ☐Yes ☐No Consume alcohol or take sedatives

☐Yes ☐No Trouble breathing through nose

Patient Signature: ______________________________ Date: ______________

HEALTH AND MEDICAL HISTORY (CONTINUED)

Do you have, or have you experienced any of the following:

- ☐Yes ☐No Heart Disorder/ Heart Attack
- ☐Yes ☐No Heart Murmur
- ☐Yes ☐No Mitral Valve prolaps
- ☐Yes ☐No Heart Pacemaker
- ☐Yes ☐No Heart Palpitations
- ☐Yes ☐No Heart Valve Replacement
- ☐Yes ☐No Irregular Heartbeat
- ☐Yes ☐No Blood Pressure ___ High ___ Low
- ☐Yes ☐No Stroke
- ☐Yes ☐No Bleeding Easily
- ☐Yes ☐No Bruising Easily
- ☐Yes ☐No Cancer of ________________
- ☐Yes ☐No Chemo ______ Radiation _____
- ☐Yes ☐No Anemia
- ☐Yes ☐No Asthma
- ☐Yes ☐No Birth Defects
- ☐Yes ☐No Diabetes
- ☐Yes ☐No Epilepsy
- ☐Yes ☐No Emphysema
- ☐Yes ☐No Glaucoma
- ☐Yes ☐No Gastroesophpgeal Reflex (Gerd)
- ☐Yes ☐No Hemophilia
- ☐Yes ☐No Hepatitis
- ☐Yes ☐No History of Substance Abuse
- ☐Yes ☐No Hypoglycemia
- ☐Yes ☐No Huntington's Disease
- ☐Yes ☐No Kidney Disease
- ☐Yes ☐No Liver Disease
- ☐Yes ☐No Leukemia
- ☐Yes ☐No Migraines
- ☐Yes ☐No Meniere's Disease
- ☐Yes ☐No Multiple Sclerosis
- ☐Yes ☐No Muscular Dystrophy
- ☐Yes ☐No Neuralgia
- ☐Yes ☐No Osteoarthirtis
- ☐Yes ☐No Osteoporosis
- ☐Yes ☐No Overian Cysts
- ☐Yes ☐No Parkinson's Disease
- ☐Yes ☐No Rhuematic Fever
- ☐Yes ☐No Rhuematoid Arthritis
- ☐Yes ☐No Scarlet Fever
- ☐Yes ☐No Thyroid Problem
- ☐Yes ☐No Tuberculosis
- ☐Yes ☐No Intestinal Disorder
- ☐Yes ☐No Nervous System Disorder
- ☐Yes ☐No Anxiety
- ☐Yes ☐No Skin Disorder
- ☐Yes ☐No Urinary Tract Disorder
- ☐Yes ☐No Chronic Fatigue
- ☐Yes ☐No Fibromyalgia
- ☐Yes ☐No Cold hands and feet
- ☐Yes ☐No Depression
- ☐Yes ☐No Difficulty concentrating
- ☐Yes ☐No Difficulty breathing at night for sleep
- ☐Yes ☐No Dizziness
- ☐Yes ☐No Excessive Thirst
- ☐Yes ☐No Fainting
- ☐Yes ☐No Fluid Retention
- ☐Yes ☐No Frequent colds/flu
- ☐Yes ☐No Frequent cough
- ☐Yes ☐No Frequent ear infections
- ☐Yes ☐No Frequent sore throat
- ☐Yes ☐No Frequent awaking at night - number of times _____
- ☐Yes ☐No Hearing impairment
- ☐Yes ☐No Memory Loss
- ☐Yes ☐No Hay Fever
- ☐Yes ☐No Insomnia
- ☐Yes ☐No Muscle aches
- ☐Yes ☐No Muscle fatigue
- ☐Yes ☐No Muscle spasms
- ☐Yes ☐No Muscle tremors
- ☐Yes ☐No Poor circulation
- ☐Yes ☐No Psychiatric Care
- ☐Yes ☐No Recent weight gain
- ☐Yes ☐No Recent weight loss
- ☐Yes ☐No Sinus problems
- ☐Yes ☐No Shortness of breath
- ☐Yes ☐No Slow healing sores
- ☐Yes ☐No Speech difficulties
- ☐Yes ☐No Swollen, stiff or painful joints
- ☐Yes ☐No Tired muscles

Additional Information ____

____

SURGICAL HISTORY *Have you had any of the following:*

- ☐Yes ☐No General Anesthesia
- ☐Yes ☐No Adnoids removed
- ☐Yes ☐No Tonsils removed
- ☐Yes ☐No Jaw Joint Surgery
- ☐Yes ☐No Orthognathic Surgery
- ☐Yes ☐No Oral Surgery

Removal of third molar (wisdom teeth) Other

- ☐Yes ☐No Other surgery

please list below

Other types of surgery

____

Patient Signature: Date:

CURRENT SYMPTOMS

Head Pain

Location		*Recent*	*Chronic*	*Severity*			*Duration*			*Frequency*		
L=Left R=Right B=Bilateral			*(over 6 mo.)*	*Mild*	*Mod*	*Severe*	*Min.*	*Hrs.*	*Days*	*Occasional*	*Frequent*	*Constant*
L R B	Frontal (Forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Parietal (Top of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Occipital (Back of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Temporal (Temple area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

Jaw Pain
☐L ☐R Jaw pain with opening
☐L ☐R Jaw pain when chewing
☐L ☐R Jaw pain at rest

Jaw Joint Sounds
☐L ☐R Jaw sounds with opening
☐L ☐R Jaw sounds when chewing
☐L ☐R Jaw sounds at rest

Jaw Locking
☐Yes ☐No Jaw locks closed
☐Yes ☐No Jaw locks open

Jaw Joint Symptoms
☐Yes ☐No Teeth clenching
☐Yes ☐No Teeth grinding

Eye Related Conditions
☐Yes ☐No Blurred vision
☐Yes ☐No Double vision
☐Yes ☐No Eye pain
☐Yes ☐No Pain or pressure behind the eyes
☐Yes ☐No Extreme sensitivity to light (photophobia)
☐Yes ☐No Wear of glasses or contact lenses

Ear Related Conditions
☐L ☐R Buzzing in the ears
☐L ☐R Ear congestion
☐L ☐R Ear pain
☐L ☐R Hearing loss
☐Yes ☐No Itchiness or Stuffiness in ears
☐L ☐R Pain behind the ear
☐L ☐R Pain in front of the ear
☐L ☐R Recurrent ear infections
☐L ☐R Ringing in the ear (Tinnitus)

Throat Related Conditions
☐Yes ☐No Chronic sore throat
☐Yes ☐No Difficulty swallowing
☐Yes ☐No Swollen glands
☐Yes ☐No Thyroid enlargement
☐Yes ☐No Tightness in throat
☐Yes ☐No Constant feeling of a foreign object in throat

Neck Related Conditions
☐Yes ☐No Limited movement of neck
☐Yes ☐No Neck pain
☐Yes ☐No Numbness in hands or fingers
☐Yes ☐No Swelling in the neck

Patient Signature: Date:

Shoulder Related Conditions

☐Yes ☐No Shoulder pain
☐Yes ☐No Shoulder stiffness
☐Yes ☐No Tingling in hands or fingers

Back Related Conditions

☐Yes ☐No Back pain - lower
☐Yes ☐No Back pain - middle
☐Yes ☐No Back pain - upper
☐Yes ☐No Sciatica
☐Yes ☐No Scoliosis

Mouth and Nose Related Conditions

☐Yes ☐No Dry mouth
☐Yes ☐No Chronic sinusitis
☐Yes ☐No Frequent snoring
☐Yes ☐No Burning tongue
☐Yes ☐No Broken teeth
☐Yes ☐No Frequent biting of the cheek

Sleep Conditions

Sleep Positions ☐ Side ☐ Back ☐ Stomach
Is it easy to fall asleep? _______
Do you feel rested upon AM waking?
Stopped breathing during sleep?_____
Average hours of sleep per night?
Do you wake often during the night? ______
Gasping or Choking during sleep?
Have you ever had a Sleep Study (PSG)?____

HISTORY OF SYMPTOMS

On what date, or approximate date, did this condition or symptoms first occur? ______________________________
☐Yes ☐No Does any family member have the same or similar problem? If yes, please explain. ______________________
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? ______________________

If yes, please complete Trauma History Section, enclosed as a separate form.

CONTINUED OR ADDITIONAL INFORMATION
(DO NOT USE THIS SECTION FOR ACCIDENT OR TRAUMA HISTORY)

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I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: Date:

Parent/Guardian Signature (if patient is a minor): ______________________________ Date: ______________

Dr. Iris Kivity-Chandler

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The Personal Information Protection & 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 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 basis, to process payments and to collect unpaid accounts. All this information will be kept private and confidential; it will be accessible to you upon request.

I give permission to Dr. Kivity-Chandler to collect, use and disclose personal information about ______________________ for the purposes indicated.
Patient name

________________________ Signature

________________________ Print name

________________________ Date

________________________ Signature of witness