whiterock orthodontic center

Certified Specialists in Orthodontics

PATIENT INFORMATION

PATIENT NAME:_____ **SEX: M/F**

BIRTHDATE: (mm/dd/yyyy) _____/_____/_____ **AGE:**_____

ADDRESS:_____

POSTAL CODE: _____ **HOME PHONE: ( )**_____

OCCUPATION: _____

EMPLOYER: _____

WORK PHONE: (_____**)**_____**CELL PHONE: (**_____**)**_____

DENTIST NAME: _____**REFERRAL SOURCE:** _____

DO YOU HAVE DENTAL INSURANCE COVERING ORTHODONTICS?_____

WOULD YOU LIKE EMAIL REMINDERS FOR APPOINTMENTS? YES/NO

EMAIL:_____

PLEASE NOTE:

- **Regular visits to your dentist must continue during orthodontic treatment**
- **Some appointments will infringe on school time or work**

MAIN CONCERN/REASON FOR ORTHODONTIC CONSULTATION:_____

_____

310 - 1959 152nd Street, White Rock, BC V4A 9E3
T: 604 535 3028 F: 604 535 0769
www.whiterockortho.com

Dr Jay Nagamatsu Inc
Certified Specialist in Orthodontics

Dr Dorothy A Sonya Inc
Certified Specialist in Orthodontics

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HAVE YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Rheumatic Fever:	yes	no	Diabetes:	yes	no
Chronic kidney problems:	yes	no	Lung problems:	yes	no
Epilepsy:	yes	no	Prolonged bleeding:	yes	no
Heart problems:	yes	no	Liver problems:	yes	no

Do you have any allergies? Yes No If yes, to what?_____

Do you have any condition that could affect your immune system (e.g. AIDS, HIV, or Leukemia?) Yes No If yes, please describe your condition:_____

_____

Do you have any medical problems? Yes No If yes, what is your problem?_____

_____

Do you take any medication? Yes No If yes, what medication? _____

_____

When was your last dental checkup and cleaning? _____

Do you have any of the following habits?

Thumb/sooth sucking	yes	no	Nail biting	yes	no
Grinding teeth at night?	yes	no	Mouth breathing?	yes	no
Snoring?	yes	no			

Has any member of the family had any orthodontic treatment? Yes No

Have you had any previous orthodontic consults or treatment? Yes No

Do you play any musical instruments? Yes No If yes, what?_____

Do you smoke or chew tobacco? Yes No

For women: Are you pregnant? Yes No

I give permission to allow Drs. D. Sonya and J. Nagamatsu to report any findings to my dentist or any other dental professional as they deem necessary. I also give permission for any records made in the process of examination, treatment and retention to be used for purposes of research, education or publication in professional journals.

Signature: _____

Date: _____

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