

# **ADULT HEALTH QUESTIONAIRE**

(Confidential information necessary for your files and your health)

**Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name** (first)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Birthdate**\_\_\_\_\_\_\_\_\_\_\_\_\_**Age**\_\_\_\_\_**Gender** **M / F**

**Home #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Would you like to receive appointment reminders by text? Y or N**

**E-mail**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Postal Code**\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dentist** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse/Nearest Relative** (first)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell** #\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PC** \_\_\_\_\_\_\_\_\_\_\_\_\_

(if different from Patient)

*Please check box*

1. Are you in good health? YES  NO

2. Have you previously been or are currently under the care of a health care professional for any kind of

condition or syndrome? YES  NO

If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you ever been hospitalized or had a serious illness or accident? YES  NO  If Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Please list any medications you are currently taking.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please check any of these medications you may have taken in the past year:

Penicillin Blood thinners Digitalis Bisphophonates

Cortisone Tranquilizers Thyroid Other\_\_\_\_\_\_\_\_\_\_

Nitroglycerin Dilantin Aspirin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Please check any of the items below that you have ever a bad reaction to:

Local Anesthetics Codeine Insulin Barbiturates LATEX

Ibuprofen Penicillin Aspirin Iodine Metals: \_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_

7. Please list any illness:

You currently have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have had in the past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you suffer frequent colds? YES  NO

9. Do you have difficulty breathing through your nose? YES  NO

10. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? YES  NO

11. Have you **ever** (at any age) had an injury to the head, neck, face, teeth or chin? (ie. Stitches, concussions, whiplash) YES  NO

If Yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Is there any other information I should know about your health or previous dental treatment? YES  NO

If Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Are you pregnant? YES  NO

14. Do you have a metal or latex sensitivity: YES  NO

15. Have you previously or do you currently wear an appliance for jaw joint issues?­­­­­­­­­­­­ ­­­­­­­­­ YES  NO

16. Do you see a dentist for regular check ups/cleanings? (date of your last checkup?) YES  NO

17. Have you ever been told that you require antibiotics prior to dental treatment? YES  NO

18. Have you had a recent exposure to any communicable infectious diseases? (measles, chicken pox or Tuberculosis) YES  NO

19. In the last 24 hours have you had a new cough, shortness of breath, fever, chills, diarrhea or other flu-

like symptoms? If yes, please explain YES  NO

20. What is your main reason for seeking orthodontic care? Do you have specific questions you would like answered today?

## INSURANCE INFORMATION

**Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group/Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I.D./Cert.No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **ACCOUNTING INFORMATION**

**Responsible Billing Party, (if different from patient**)

**Name**: **(first)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I CONFIRM THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE DATE OF COMPLETION.**

**By signing below, you are also consenting to receive email communication from The Orthodontic Centre at Northland. This includes, but is not limited to; payment receipts, appointment reminders and occasional information about current events. If you prefer not to receive emails from The Orthodontic Centre at Northland, please let us know.**

**Signature: Print Name: Date:**

**The Orthodontic Centre at Northland**

**Northland Professional Building**

**4600 Crowchild Trail NW, Suite 207,**

**Calgary, AB T3A 2L6**

**info@theorthodonticcentre.ca**