**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**