Dr. Manisha Jindal
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Certified Specialist in Orthodontics

Patient Information

Date:_____________________________

Patient Name:____

Gender: []M []F DOB: Month_____Day______Year_____

Address____

City_____________Province____Postal Code________Home Phone#______________

Email______________________Dentist_________________Physician______________

Dental Insurance: []Yes []No Name of Policy Holder:___________________________

Complete for Child Patient:

School____Grade_____

Hobbies/Sports/Instruments____

Father/Guardian Name____

Home #_________________Work#_________________Cell#_____________________

Address:

❑ Same as above OR

____

Street City Prov Postal Code

Mother/Guardian Name____

Home #_________________Work#_________________Cell#_____________________

Address:

❑ Same as above OR

____

Street City Prov Postal Code

Who is responsible for the account?

Name_____________________Insurance: Yes/No Relationship to Patient__________

Name_____________________Insurance: Yes/No Relationship to Patient__________

Complete for Adult Patient:

Work Phone #_________________________Cell phone # _______________________

Spouse Name_________________________Phone #___________________________

Signature Of Patient/Guardian____________________________Date_____________

Medical History

	Yes	No	Details:
Is the patient in good health?	( )	( )	If No, explain ______
Any major/unusual illnesses?	( )	( )	If Yes, explain ______
Seeing physician other than regular checkups?	( )	( )	If Yes, explain ______
Currently taking any medications?	( )	( )	List ______
Do you have any allergies (eg food/medication/latex/penicillin etc)?	( )	( )	List ______
Do you have any drug sensitivites?	( )	( )	List ______
Have you ever been hospitalized?	( )	( )	If yes, explain ______
Have you ever taken bisphosphonates?	( )	( )	If yes, when/how much/for what? ______
Is there any chance you may be pregnant?	( )	( )	If yes, how many weeks?______

Please check ( ) if patient has or has had any of the following

	Yes	No
Anemia	( )	( )
Blood disease	( )	( )
Prolonged bleeding	( )	( )
Hepatitis	( )	( )
Liver disease	( )	( )
Jaundice	( )	( )
Heart disease	( )	( )
Angina	( )	( )
Heart attack	( )	( )
Congenital heart defects	( )	( )
Stroke	( )	( )
Heart Surgery	( )	( )
Heart Pacemaker	( )	( )
Mitral Valve Prolapse	( )	( )
Blood pressure (high/low)	( )	( )
Heart murmer	( )	( )

	Yes	No
frequent colds/flu	( )	( )
Tuberculosis	( )	( )
Diabetes	( )	( )
Hypoglycemia	( )	( )
Endocrine problems	( )	( )
Bone disorders/fracture	( )	( )
Epilepsy/seizures	( )	( )
Herpes	( )	( )
Rheumatic fever	( )	( )
Rheumatic heart disease	( )	( )
Emotional disturbance	( )	( )
Depression	( )	( )
Anxiety	( )	( )
Tumour or cancer	( )	( )
Eye disease	( )	( )
Do you require prophylactic medication?	( )	( )

	Yes	No
Frequent cold sores	( )	( )
Sinus trouble	( )	( )
Tonsillitis	( )	( )
Tonsils removed? Age: ______	( )	( )
Adenoids removed? Age ______	( )	( )
Adenitis	( )	( )
Mouth breathing: while awake	( )	( )
while sleeping	( )	( )
Prosthetic/artificial joints	( )	( )
Joint pain	( )	( )
Accidents to head/face/teeth	( )	( )
Asthma	( )	( )
Venereal disease	( )	( )
Frequent headaches	( )	( )
Arthritis	( )	( )
Do you have AIDS or are you HIV positive	( )	( )

Growth information for patients under 16 years of age

Father's height ________ Mother's height __________ Girls: Has she started menstruation? Yes No When? _________

Patient resembles ( )Father ( )Mother ( )Neither Parent Boys: Has his voice changed? Yes No When?__________

Name and ages of patients brothers and sisters______________________________

Dental History

	Yes	No	
Has the patient had any trauma to teeth?	( )	( )	If Yes, explain______
Has the patient had any severe head or face injuries?	( )	( )	If yes, explain______
Has the patient had history of thumb/finger sucking?	( )	( )	If yes, have they stopped?______
Has the patient had history of any other mouth habits?	( )	( )	If yes, describe:______
Does the patient play musical (wind) instruments?	( )	( )	If yes, which one______
Has the patient consulted an orthodontist previously?	( )	( )	
Has the patient has any previous orthodontic treatment?	( )	( )	If yes, describe______
Has the patient every has a bad dental experience?	( )	( )	If yes, explain______
Is the patient fearful of having dental work done?	( )	( )	
Does the patient have any discomfort with their current bite?	( )	( )	If yes, explain______
Does the patient have any speech problems?	( )	( )	If yes, describe______

Please check ( ) if patient has or has had any of the following

	Yes	No
History of Jaw joint (TMJ)	( )	( )
Clenching teeth	( )	( )
Grinding teeth	( )	( )
Muscle soreness near head /neck/ jaw joint	( )	( )

	Yes	No
Headaches	( )	( )
Jaw joint soreness/pain	( )	( )
Jaw joint clicking	( )	( )
Jaw joint popping	( )	( )

	Yes	No
Jaw joint locking (open/closed)	( )	( )
Difficulty opening mouth	( )	( )
Ringing in the ears	( )	( )

Is there any other information that may be helpful?______________________________

Why are you seeking orthodontic consultation?______________________________

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record, I will inform the practice. I also give my aurthorization for an orthodontic exam to be performed for the above mentioned patient Signed______________________________Date: ______________