Shine Orthodontics

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.
www.shineorthodontics.ca

1 Tell Us About Your Child

Today's Date: _____
Child's Name:_____ Nickname:_____
Birthday:_____ Age:_____ □ Male □ Female
School:_____ Grade: _____
Hobbies / Sports: _____
List Siblings with Age:_____
_____

Child's Address: _____
Child's Home #:_____ Cell #: _____
Child's E-mail Address: _____
Patient resides with □ Both parents □ Mother □ Father
□ Joint □ Other _____

Please describe your child's orthodontic concern(s).
_____
Have you consulted an orthodontist regarding the concern(s)?
_____
Is your child sensitive or self-conscious about his/her teeth?
_____
Any changes in your child's bite or tooth alignment recently?
_____

Whom may we thank for referring you to our office?
_____
Any friends / family members in our practice?
_____

2 Growth Information

Growth is an important factor in orthodontic treatment planning. Your answers to the following questions are needed for Dr. Lo to determine the best treatment plan.

Has your son/daughter reached puberty? □ No □ Yes
Girls: Has she started menstruation? □ No □ Yes, when?
Boys: Has his voice changed? □ No □ Yes, when?

Father's Height: _____ Mother's Height: _____
Child's Height: _____ Adopted? □ No □ Yes
Do you feel your child's growth is complete? □ No □ Yes
Explain _____
Have parents / siblings had ortho treatment? □ No □ Yes

3 Parent's Information

Parents' marital status □ Married □ Separated □ Divorced
□ Widowed □ Step Parent(s) □ Single □ Other _____

Parent 1 □ Person Responsible for Account
□ Mr. □ Mrs. □ Ms. □ Dr. Name: _____
Address (if different): _____
E-mail Address: _____
Home #: _____ Cell #: _____
Work #: _____Occupation: _____
Employer: _____
Business Address: _____
Preferred Method of Correspondence: □ Email □ Canada Post

Parent 2 □ Person Responsible for Account
□ Mr. □ Mrs. □ Ms. □ Dr. Name: _____
Address (if different): _____
E-mail Address: _____
Home #: _____ Cell #: _____
Work #: _____Occupation: _____
Employer: _____
Business Address: _____
Preferred Method of Correspondence: □ Email □ Canada Post

Alternative contact in case of emergency
Name: _____
Relationship: _____
Home #: _____ Cell #: _____

4 Dental Insurance

Insurance Company Name: _____
Insurance Company Address: _____
Policy No. _____
Identification No. _____
Policy Holder's Name: _____ DOB_____

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5 Dental History

Dentist's Name:_____ Dentist's Phone: _____
Date of Last Visit: _____ Reason of Last Visit: _____
Is there any unfinished care to be completed with your child's dentist? _____
Frequency of Dental Checkups: □ Twice a year □ Once a year □ Only if a problem exists

Yes No Is your child presently in any dental pain? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is there a history of finger sucking habit or tongue habit? _____
Yes No Is your child a mouth breather? □ Awake □ Asleep _____
Yes No Is there a history of speech problems? _____
Yes No Are there concerns of sleep apnea? _____
Yes No Does your child play any mouth musical instrument? _____
Yes No Have teeth (either primary or permanent) been removed? _____

Has your child had a history of:

□ Grinding / Clenching teeth □ Muscular soreness around head & neck □ Headaches (more than normal)
□ Ringing in the ears □ Jaw joint soreness □ Jaw joint popping □ Jaw joint clicking

6 Medical History

Family Doctor's Name: _____ Family Doctor's phone: _____
Date of Last Visit: _____ Reason of Last Visit: _____

Yes No Is your child currently under a physician's care? _____
Yes No History of a major illness or any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Is your child taking any medication? _____
Yes No Is there any allergies, e.g. Latex, medications, metal? _____
Yes No Has your child's tonsils and/or adenoids been removed? _____
Yes No Has your child been in a risk group for AIDS? _____
Yes No Does the patient need extra help with instructions? _____

Circle any of the medical conditions below that the patient has had or currently has

Abnormal bleeding/Hemophilia	Diabetes	Pneumonia	Asthma or Hayfever
Hepatitis/Liver problems	Herpes	Rheumatic Fever	Tuberculosis
High blood pressure	Epilepsy/Seizure	HIV/AIDS	Radiation/Chemotherapy
Congenital Heart Defect	Heart problems	Anemia	Arthritis
Bone Disorders	Nervous Disorders	Kidney problems	Tumor or Cancer

Any other information you feel we should be aware of? _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Lo to perform a complete orthodontic evaluation.

Signature: _____ Date: _____
Name: _____ Relationship to patient: _____