Milton Orthodontics

Dr. Eva Berka BSc, DDS, MSc(Ortho), FRCD(C)
Certified Specialist in Orthodontics

PATIENT INFORMATION

Date: _____

Name: _____ Date of Birth: ___/___/___ Age: _____
D M Y

Gender: _____

Street: _____ Suite # _____

City: _____ Postal Code _____ Home Tel: _____

Cell: _____ Bus. Tel: _____ E-Mail: _____

School/Employer _____ Grade (if applicable) _____

Dentist: _____ Physician: _____

Siblings: Names/Ages _____

Whom can we thank for referring you to our office? _____

What is the main orthodontic concern? _____

Have we treated any other family member? □ Yes □ No _____

Have you ever had an orthodontic consultation? □ Yes □ No _____

Do you have Orthodontic Insurance? □ Yes □ No _____

What are the 2 key things that need to happen during orthodontic treatment for you to feel satisfied with your experience in our office?

1. _____
2. _____

PARENT INFORMATION (IF APPLICABLE)

MOTHER/FATHER/PARENT/GUARDIAN INFORMATION (PLEASE CIRCLE)

Name: _____ Employer: _____

Street: □ same as above _____ Suite # _____

City: _____ Postal Code: _____ Home Tel: _____

Business # _____ Cell # _____ E-mail _____

MOTHER/FATHER/PARENT/GUARDIAN INFORMATION (PLEASE CIRCLE)

Name: _____ Employer: _____

Street: □ same as above _____ Suite # _____

City: _____ Postal Code: _____ Home Tel: _____

Business # _____ Cell # _____ E-mail _____

MEDICAL HISTORY

Any change in general health in the past year? _____

Any Serious Illnesses or Recent Hospitalizations: _____

Taking any medication? _____

Any allergies or drug reactions? _____

Does the patient require additional antibiotics for dental treatment? □ Yes □ No

For women only – Are you pregnant? □ Yes □ No, and if so, what is the expected delivery date? _____

Do you have or have you ever had any of the following?

Heart Murmur □
Heart Disorder □
Rheumatic Fever □
Blood Disorder □
Asthma □

Seasonal Allergies □
Respiratory Disorders □
Diabetes □
Epilepsy/Seizures □
Mental Illness □

Kidney Disorders □
Mononucleosis □
HIV □
Osteoporosis □
Joint Replacement □
Liver Disorders/Hepatitis □

Is there a tendency to breathe through the mouth? □ Yes □ No

Does the patient currently smoke? □ Yes □ No

Any additional comments or conditions you feel we should be aware of? _____

_____

DENTAL HISTORY

Last Dental Visit? _____ X-rays? _____

Dental Problems? i.e. Cavities, gum disease, bleeding upon brushing □ Yes □ No _____

Any trauma to teeth or jaws? □ Yes □ No_____

Habits? i.e. Finger, thumb, lip biting □ Yes □ No _____

Difficulty with speech or chewing? □ Yes □ No _____

Concern over the appearance of the teeth? _____

Are there any orthodontic fears or concerns? □ Yes □ No _____

Do the jaws click, crack or lock upon opening? □ Yes □ No _____

Is there grinding or clenching of teeth? □ Yes □ No _____

Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal college of Dental Surgeons of Ontario and the law. Only necessary information is collected and we only share information with your consent.

I hereby consent that Dr. Berka or her designated staff may release any information pertaining to orthodontic treatment to my dentist or related health professional:

Signature of patient/parent or guardian _____ Date: _____