RESTORATION™ ORTHODONTICS

For your benefit, please have this form completed and bring it with you to your first visit.

PATIENT NAME: _____ ☐ MALE ☐ FEMALE ☐ OTHER

INSURANCE: ☐ Yes ☐ No ☐ Dual BIRTHDATE: _____

ADDRESS: _____ CITY: _____

POSTAL CODE: _____ HOME PHONE #: _____ PARENT CELL #:_____

REFERRED BY:_____ DENTIST:_____

Reason for seeking treatment: _____

Is any other family member a patient at our office? ☐ No ☐ Yes: _____

RESPONSIBLE PARTY INFORMATION:

MOTHER'S NAME**:** _____

CELL #: _____ WORK #: _____

EMAIL ADDRESS: _____

Address: (if different from above) _____

City: _____ Postal Code: _____

FATHER'S NAME**:** _____

CELL #:_____ WORK #: _____

EMAIL ADDRESS: _____

Address: (if different from above) _____

City: _____ Postal Code: _____

(PLEASE COMPLETE OPPOSITE SIDE)

8255 Anchor Drive Windsor, ON N8N 5G1
P: 519.948.2471 | F: 519.974.2951 | info@rotho.ca | www.rotho.ca

MEDICAL HISTORY:

Patient's Medical Doctor: _____

Has the patient ever had any of the following illnesses?

☐ Rheumatic Fever	☐ Asthma	☐ Angina	☐ Psychiatric Care
☐ Hepatitis	☐ TB	☐ Heart Disease	☐ Autism Spectrum
☐ Jaundice	☐ Scarlet Fever	☐ Thyroid Problem	☐ Emotional Disturbances
☐ Diabetes	☐ Mononucleosis	☐ Malignant Hyperthermia	☐ Learning Difficulties

1. Is your child taking any medication? ☐ No ☐ Yes: _____

2. Is your child allergic to any medication or food? ☐ No ☐ Yes: _____

3. Is there anything in your child's medical history that we should be aware of, such as dental apprehension, fainting spells, low blood sugar or low blood pressure etc? ☐ No ☐ Yes: _____

_____

4. We desire the very best result possible for your child. Is there any issue that might affect their ability to follow Instructions for brushing, flossing, elastic wear or wearing appliances? (ie. difficulties with learning, co-ordination or manual dexterity?) ☐ No ☐ Yes: _____

DENTAL HISTORY:

1. Has the child ever had an orthodontic consultation or treatment? _____

2. Does the child have any oral habits such as:
   ☐ Thumb Sucking ☐ Nail Biting
   ☐ Tongue Thrusting ☐ Teeth Grinding
   ☐ Finger Sucking ☐ Mouth Breathing

3. How often does your child brush their teeth? ☐ None ☐ 1-2x/day ☐ 3-4x/day ☐ 4-5x/day

4. When was your child's last check up and cleaning and is there any outstanding dental work required?_____

DATE: _____ **SIGNATURE**: _____

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