SHUSWAP ORTHODONTICS
YOUR SMILE SPECIALIST.

(250) 832-6558 | info@shuswaportho.com

#202 – 571 6 St NE
Salmon Arm, BC V1E 1R6

Today's Date: _____

How did you hear about us? (select all that apply, and provide details if room is provided)

☐ Facebook ☐ Instagram ☐ Our website ☐ Search Engine (e.g., Google): _____

☐ Friend: _____ ☐ Event: _____

☐ Dentist: _____ ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____ (Prefers to be called: _____)
first last

Gender: _____ Birthdate: _____/_____/_____ School: _____ Grade: _____
month day year if applicable if applicable

Phone: 1st # H C W (_____) _____ - _____ 2nd # H C W (_____) _____ - _____ 3rd # H C W (_____) _____ - _____
circle one circle one circle one

Cell Carrier: _____ Cell Carrier: _____ Cell Carrier: _____
for cell phones only for cell phones only for cell phones only

Email: _____

Mailing Address: _____
if different street address city postal code

Dentist: _____ Physician: _____

Other children in family: _____
name(s) and age(s)

RESPONSIBLE PARTIES

Adult patients: complete for yourself and/or your spouse, if either may have orthodontic insurance
Child patients: Please complete parental information

Mother
Spouse
Self
Circle one

Name: _____ Birthdate: _____/_____/_____
first last month day year

Mailing Address: _____
if different street address city postal code

Phone #: H C W (_____) _____ - _____ Employer: _____
circle one

Father
Spouse
Self
Circle one

Name: _____ Birthdate: _____/_____/_____
first last month day year

Mailing Address: _____
if different street address city postal code

Phone #: H C W (_____) _____ - _____ Employer: _____
circle one

MEDICAL HISTORY

	Yes	No	
1.	☐	☐	Does the patient smoke?
2.	☐	☐	Does the patient have any *history* of major illness?
			If yes, please explain: _____
3.	☐	☐	Is the patient *presently* under the care of a physician for a major illness?
			If yes, please explain: _____
4.	☐	☐	Is the patient currently taking any medications?
			If yes, please list: _____
5.	☐	☐	Has the patient been advised to take antibiotics or other medications before dental visits?
			If yes, please list: _____
6.	☐	☐	Does the patient have allergies to any drugs?
			If yes, please list: _____
7.	☐	☐	Does the patient have any other allergies? (E.g., seasonal, food, etc.)
			If yes, please list: _____
8.	☐	☐	Has the patient had his/her tonsils removed?
			If yes, at what age? _____
9.	☐	☐	Has the patient had his/her adenoids removed?
			If yes, at what age? _____
10.	☐	☐	If tonsils and/or adenoids have not been removed, does the patient have regular problems with them? (or: ☐ not applicable)
			If yes, please explain: _____
11.	☐	☐	Is the patient prone to colds, sore throats, and/or ear infections?
			If yes, which? _____
12.	☐	☐	Does the patient have any physical or mental considerations? (E.g., ADHD, ASD, anxiety, etc.)
			If yes, please explain: _____
13.	☐	☐	Does the patient require any extra help during appointments, or with instructions?
			If yes, please explain: _____
14.	☐	☐	Female patients: Are you pregnant or trying to become pregnant? (or: ☐ not applicable)
15.	☐	☐	Child patients: Has the patient reached puberty? (or: ☐ not applicable)
16.	☐	☐	Is the patient up to date with his/her vaccinations?
			If no, please explain: _____

17. Please select any of the following that the patient has had problems with:

☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Anemia	☐ Asthma
☐ Bleeding	☐ Bone Disorders	☐ Cleft Lip/Palate	☐ Diabetes
☐ Epilepsy/Seizures	☐ Fainting/Dizziness	☐ Hearing	☐ Heart Murmur
☐ Heart Trouble/Disease	☐Heart Valves	☐ Hemophilia	☐ Kidney Disease
☐ Liver Disease	☐ Nervous Disorder(s)	☐ Pneumonia	☐ Rheumatic Fever

☐ Other: _____

18. Please select any of the following that the patient has or has been exposed to:

☐ Hepatitis	☐ HIV/AIDS	☐ Tuberculosis	☐ STI's

19. Please describe any other medical problems not yet covered:

_____

_____

_____

**If the patient is currently experiencing pink eye, strep throat, mononucleosis, or another contagious illness, please contact our office before the new patient consultation to reschedule.

DENTAL HISTORY

	Yes	No	
20.	☐	☐	What are the patient's/parent's concerns regarding the appearance of the patient's teeth?
			If yes, please explain: _____
21.	☐	☐	Does the family have a history of an underbite? I.e., the lower teeth extend outward further than the upper teeth. (or ☐ unsure)
			If yes, what is the relationship to the patient? _____
22.	☐	☐	Have there been any injuries to the face, teeth or jaw joints?
			If yes, please explain: _____
23.	☐	☐	Does the patient have speech problems?
			If yes, has the patient had speech therapy? Please explain: _____
24.	☐	☐	Has the patient ever sucked his/her thumb or fingers?
			If yes, until what age? _____
25.	☐	☐	Does the patient snore while sleeping? (or: ☐ unsure)
26.	☐	☐	Does the patient breathe through the mouth, rather than the nose? (or: ☐ usually ☐ sometimes)
27.	☐	☐	Are there any diagnosed or suspected airway/breathing problems, including sleep apnea?
			If yes, please explain: _____
28.	☐	☐	Has the patient been informed of any missing permanent teeth?
			If yes, how many, and which teeth? _____
29.	☐	☐	Has the patient had an orthodontic consultation previously?
			If yes, when, where and for what type of orthodontic treatment? _____
30.	☐	☐	Has either parent previously had orthodontic treatment?
			If yes, which parent(s)? At which office(s)? _____
31.	☐	☐	Does the patient experience pain in the jaw joint?
			If yes, right and/or left side? _____
32.	☐	☐	Does the patient have clicking in the jaw?
			If yes, how often? _____
33.	☐	☐	Has the patient ever been diagnosed with having jaw joint (TMJ) problems?
			If yes, when? What has been done? _____
34.	☐	☐	Does the patient chew on pens, pencils, fingernails, etc.?
35.	☐	☐	Does the patient play a contact sport?
			If yes, which sport? _____
36.	☐	☐	Does the patient play a wind/brass instrument?
			If yes, which instrument? _____

37. When was the patient last seen by his/her dentist? _____
38. What was done at the last dental visit? _____
39. When is the patient scheduled to return to his/her dentist? _____
40. How often does the patient see his/her dentist? _____

I understand that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Relationship to patient: _____ Legal Guardian (if different): _____

INSURANCE BENEFITS

Please complete ALL of the insurance information below and bring with you to your appointment.

This appointment is complementary, but with this information we can help you to estimate the portion of any recommended treatment that may be covered by your insurance plan.

If you do not know what your insurance company covers, usually a quick phone call to the insurance company by the plan holder can answer these questions. Due to privacy laws in place by the companies unfortunately we are unable to call on your behalf. When you call please make sure to tell them you would like to know what your **"Orthodontic"** benefits cover.

Thank you for completing this information ahead of time. We look forward to meeting with you at your appointment.

Patient Name _____ Patient Birth Date _____

Primary Insured	**Secondary Insured**
Insured Name _____	Insured Name _____
Insured Birth Date _____	Insured Birth Date _____
Employer _____	Employer _____
Insurance Company _____	Insurance Company _____
Group/Plan/Policy # _____	Group/Plan/Policy # _____
ID/Certificate # _____	ID/Certificate # _____
Coverage % _____	Coverage % _____
Lifetime/Yearly Limit _____	Lifetime/Yearly Limit _____

SHUSWAP ORTHODONTICS
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Patient Treatment Agreement

Informed Consent

Welcome to our practice! As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time and in any place. Be assured that we have always followed provincial and national regulations and recommended universal personal protection and disinfection protocols to limit transmission of all disease in our office and continue to do so. These measures include, but are not limited to:

- screening everyone that enters our office
- limiting the number of people permitted onsite
- requiring that everyone wear a mask
- installing hospital-grade air filtration units in our office

Every aspect of our practice has been examined to ensure that there is no patient-to-staff or staff-to-staff interaction that is considered "close contact" based on proximity, duration and layers of personal protective equipment.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, we acknowledge that there is risk of exposure – as in any other public place.

Practice Obligation

Despite the low risk of transmission in our office, we are committed to notifying patients by phone or email if they were in the office at the same time as a COVID-positive person. We will also ensure that we always meet or exceed guidelines from public health authorities that reduce the risk of spread of infections in our office.

Patient Obligation

It is expected that you do not come to the office if you have any Coronavirus symptoms or if you were in close contact with someone who is infected or in self-isolation due to a suspected coronavirus infection. In addition, please let us know if you find out that you are COVID-positive after your visit and may have been in the office during the incubation stage of the coronavirus.

Our Treatment Agreement

I have read and acknowledge the obligation of Shuswap Orthodontics to inform me of any known exposure to COVID-19 that could happen during my visit. I understand and accept my personal responsibility to inform Shuswap Orthodontics of any exposure or risk related to myself. In-person attendance at my appointments will suffice as consent to assume the risks of contracting Covid-19 in the office, as in any other public space.

No signature required; for your information only