quest orthodontics

liveyoursmile.ca

Welcome to Quest Orthodontics!

To help us serve you better, please complete this form in full.
Use the fields supplied and fillout. When complete email to admin@questbraces.com

PATIENT REGISTRATION FORM

Please inform us of any future changes. All information will be kept strictly confidential.

Today's date:	Chart ID (office use only) :

Patient Information

Patient's last name	First name	Middle name	Mr. / Mrs. / Miss / Ms.	Gender: Male / Female	Birth Date: Day / Month / Year	Age

Street address:	Home phone	Cell phone

City or town	Province	Postal Code	Patient's E-Mail address

Occupation (optional)	Employer or school	Work phone

Chose clinic because/Referred to clinic by (please check as many as applicable):

__ Referred by Dr. _____ Name of regular dentist (if different than referring dentist) _____

Family/Friend Social media Close to home/work Internet/website Print ad Outdoor Ads Other (please specify) _____

If you were referred by an individual, please let us know who we can thank for referring you to us	Other family members seen here

Parent or Legal Guardian Information

(Please complete if patient is a minor or if he/she is not the person primarily responsible for their account)

Person responsible for account	Address Same as above	Home phone Same as above
		Cell phone Same as above
Relationship to patient:		

Mother's Information

Name	Address (if different from above)	Home phone	Cell phone	Work phone	E-Mail
Stepmother Legal Guardian					

Father's Information

Name	Address (if different from above)	Home phone	Cell phone	Work phone	E-Mail
Stepfather Legal Guardian					

Insurance Information

Fees for professional services are charged to the patient/parent/guardian. We will complete the necessary insurance forms so you can submit them to your insurance provider to claim any reimbursement you are entitled to under your policy.

Insurance Policy #1

Subscriber's name	Birth date	Relationship to patient	Insurance company name	Employer	Policy number	Certificate (ID) number

Insurance Policy #2

Subscriber's name	Birth date	Relationship to patient	Insurance company name	Employer	Policy number	Certificate (ID) number

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Dental History

What is the primary reason for seeking an orthodontic consultation ?

Have you received an orthodontic consultation or orthodontic treatment in the past ? ☐Yes ☐No If yes, please specify

Do you clench or grind your teeth ? Yes No If yes, please specify

Do you snore of have any breathing problems ? ☐Yes ☐No If yes, please specify

Has there ever been a history of problems with the jaw joints (TMJ) in the past ? ☐Yes ☐No If yes, please specify

Has there ever been a major injury to the face, mouth, teeth, or chin ? ☐Yes ☐No If yes, please specify

Do you currently receive regular dental care by a general dentist ?
☐Yes ☐No If yes, approximate date of last visit _____

How often do you brush your teeth ?
☐ 1 time / day
☐ 2 times / day
☐ 3 or more times / day
☐ Do not brush my teeth daily

How often do you floss your teeth ?
☐ 1 or more times / day
☐ I do not floss my teeth on a regular basis

Other than regular fillings and cleanings, have you (patient) received any major dental treatment in the past ? ☐Yes ☐No If yes, please specify

Medical History

Physician's Name	Physician's phone number	General physical health ☐Good ☐Fair ☐Poor

Are you currently taking any prescription medications? If yes, please specify

Are you currently taking any over the counter medications? If yes, please specify

Do you smoke or use recreational drugs ? If yes, please specify

For women: Are you pregnant ?
☐Yes (weeks _____) ☐No ☐Unsure

Have you (patient) ever had any of the following? (please check all applicable)

Abnormal Bleeding / Hemophilia	Aids / HIV	Alcohol / Drug Abuse
Anemia	Arthritis	Artificial Bones / Joints / Valves
Asthma	Colitis	Blood Transfusion
Cancer / Chemotherapy	Diabetes	Congenital Heart Defect
Cystic Fibrosis	Emphysema	Difficulty Breathing
Emotional Problems	Epilepsy	Fainting Spells
Frequent Headaches	Glaucoma	Hay Fever
Heart Attack	Surgery	Heart Murmur
Hepatitis	Lupus	Herpes / Fever Blisters
High Blood Pressure	Liver Disease	Kidney Problems
Hospitalization (overnight)	Low Blood Pressure	Mitral Valve Prolapse
Pacemaker	Psychiatric Problems	Rheumatic / Scarlet Fever
Seizures	Radiation Treatment	Sickle Cell Disease / Trait
Shingles	Skin Problems	Sinus Problems
Stroke	Thyroid Problems	Venereal Disease
Ulcers	Tuberculosis	Alcohol / Drug Abuse

If you have had any of the above, please provide further details on treatment received and current status

Please describe any medical condition not listed above

Do you have any allergies to foods, medications, or materials ? If so, please list and describe reaction to exposure if known

WHEN COMPLETED EMAIL FORM TO admin@questbraces.com

I understand that the information provided above is complete and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to promptly inform this office of any changes in my medical status.