Guildford Orthodontic Centre
#200-10203 152A Street, Surrey, B.C. V3R 4H6 Phone: **604-589-2212**
Dr. Paul Pocock, Inc. Dr. Aly Kanani, Inc. Fax: 604-589-2269
Certified Specialists in Orthodontics www.guildfordorthodontics.com

#200 - 10203 152A St, Surrey, BC V3R 4H6
Ph# 604-589-2212 E-mail: office@guildfordorthodontics.com Fax# 604-589-2269

Name_____Age_____Sex_____Date of Birth_____
Last First

Address_____Tel#_____
Street City Postal Code

School_____Grade_____

Best Fax #_____Best Cell #_____Best E-Mail Address_____

Father's Name_____
Last First M.I

Marital Status
[] single [] Married [] Separated [] Divorced [] Widowed [] Remarried

Home Address_____Home Tel #_____
Employed by_____Occupation_____Position_____
Office Address_____Work Tel #_____

Mother's Name_____
Last First M.I

Marital Status
[] Single [] Married [] Separated [] Divorced [] Widowed [] Remarried

Home Address_____Home Tel #_____
Employed By_____Occupation_____Position_____
Office Address_____Work Tel #_____

Patient's Family Dentist_____

Patient's Family Physician_____

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

If responsible party is other than the patient's parents, please give information: [] Not applicable

Name_____Reltionship to patient_____

Address:_____Tel #_____

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MEDICAL HISTORY

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	[]	[]	Persistent Headaches	[]	[]
Heart Murmur	[]	[]	Neck Pains	[]	[]
High Blood Pressure	[]	[]	Nerve or Brain Disease	[]	[]
Heart Attack/Stroke	[]	[]	Migraine	[]	[]
Blood Vessel Disease	[]	[]	Epilepsy	[]	[]
Blood Disorder	[]	[]	Mental Health Problems	[]	[]
AIDS/HIV Infection	[]	[]	Bone Disorders	[]	[]
Hepatitis	[]	[]	Arthritis (Any type)	[]	[]
Diabetes	[]	[]	Sleep Apnea	[]	[]
Ulcers	[]	[]	Ear Disorder	[]	[]
Herpes (Any type)	[]	[]	Sinus Infection	[]	[]
Psoriasis	[]	[]	Swollen Glands	[]	[]
Cancer	[]	[]	Allergies	[]	[]

Comments_____

Please list any other significant information about the patient's medical history:

_____

_____

Yes No

[] [] Is patient under a physician's care at present? If yes, reason_____

[] [] Is patietnt presently, or has patient ever been, under the care of a psychiatrist or psychologist?
If yes describe_____

[] [] Is patient currently taking any medication? If yes describe_____

[] [] Is the patient allergic to any medications? (Eg: aspirin, penicillin, etc.) if yes, what?_____

[] [] Has patient ever had a general anesthesia? When?_____

DENTAL HISTORY

[] [] Do any of your teeth hurt? If yes, upper right [] upper left [] lower right [] lower left []

[] [] Have any wisdom teeth been removed? How many?_____ [] []

Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe_____

[] [] Have you ever had any previous orthodontic treatment (braces)? If yes, when?_____
If yes, doctors name and address_____

[] [] Have there been any injuries to your mouth or teeth? If yes, describe_____

[] [] Have you ever had any injury in the head or neck area? If yes, describe_____

[] [] Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe_____

[] [] Have you ever had any surgery in the head or neck area? If yes, describe_____

[] [] Do you clench or grind your teeth? If yes, while sleeping [] Under stress [] Other_____

[] [] Do your jaw muscles ever feel tired? If yes, when_____

[] [] Do you ever notice soreness, lightness or pain in the muscles around the jaws and face? If yes, describe
_____

Does it hurt to chew? If yes where does it hurt?_____

Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe

	Right	Left	Since when_____ During what activity_____
Clicking	[]	[]	
Grating	[]	[]	

[] [] Did these joint sounds begin gradually or suddenly? Gradually [] Suddenly []

[] [] Was there some specific event that started the joint sounds? If yes, describe_____ []

[] Have you experienced difficulty in opening or closing your jaws? If yes, describe_____

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[] [] Have your jaws ever "locked" closed? If yes, describe_____
[] [] Have your jaws ever "locked" wide open? If yes, describe_____

Yes No
[] [] Do you have pain in your jaw joints? If yes, right [] left [] since when?_____
[] [] Did your pain start gradually or suddenly? [] gradually [] suddenly
[] [] During what activity?_____Describe nature of pain_____
What increases the pain?_____What decrease the pain_____

Do you have any of the following habits?

Yes No
[] [] Finger/Thumbsucking
[] [] Lip Biting
[] [] Nail Biting
[] [] Gum Chewing
[] [] Ice Chewing

GROWTH AND DEVELOPMENT:

[] [] Has patient reached adolescent growth?_____
[] [] Girls - has monthly cycle started yet? If so, when_____
[] [] Boys - has voice changed yet? If so, when_____
[] [] Is the patient adopted? Does patient know? Yes [] No []
[] [] Are there any learning disabilities? If yes, explain_____
Patient's present height_____Expected height of patient_____
Fathers Height_____Mother's height_____
[] [] Are there other children in the family?
Names and ages_____
[] [] Has any other member of the family had orthodontic treatment?
[] [] Has any other member of the family been a patient in this office?

Please describe why you sought this consultation_____

[] [] Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment
_____

Any information you can give me concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies.

_____
_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____
Signature of Responsible Adult Date

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ADDITIONAL INFORMATION FOR ADULT PATIENTS ONLY

Patients often request changes in the look of their teeth, facial appearances and relief from pain or discomfort. Please help us understand your concerns by checking off the following information and circling the applicable words. Please return this form to our office prior to your next appointment. Thank you.

Teeth: If your teeth could be changed, how would you like them to change?

[ ] Straighten the front teeth - upper / lower
[ ] Straighten the back teeth - upper / lower
[ ] Make the upper front teeth longer / shorter
[ ] Move upper teeth - forward / backward
[ ] Move lower teeth - forward / backward
[ ] Make the line of the upper front teeth more level
[ ] Move the midline of the upper / lower teeth to the left / right
[ ] Other_____

Face: If your facial appearance could be changed, what would you change?

[ ] Get rid of sag under lower jaw
[ ] Move chin - forward / backward
[ ] Move chin - right / left
[ ] Move lower lip - forward / backward
[ ] Move upper lip - forward / backward
[ ] Move the area around my nose forward / backward
[ ] Move the profile of my nose - longer / shorter
[ ] Move the area around my eyes - forward / backward
[ ] Make my cheekbones - larger / smaller
[ ] Show more / less of my teeth / gums when I smile
[ ] Make my lips closer together / farther apart when my teeth are touching
[ ] Make my lips not touch and roll out when I close my lips
[ ] Make my face more - narrow / wide
[ ] Reduce the width / fullness of my lower jaw behind my mouth
[ ] Other_____

Symptoms: If you want to reduce pain or discomfort where would it be located?

[ ] In front of my ears - right / left
[ ] Below my ears - right / left
[ ] Above my ears - right / left
[ ] In my ears - right / left
[ ] Neck - right / left
[ ] Shoulders - right / left
[ ] Temples - right / left
[ ] Teeth
[ ] Sinuses
[ ] Eyes - right / left
[ ] Other_____

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Name_____Date_____

ADDITIONAL INFORMATION FOR CHILDREN AND TEENAGE PATIENTS ONLY

Patient: Please complete the following questions:

Is there anything you don't like about your teeth?

Is there anything you would like to see changed about your teeth and smile?

What questions would you like to have answered at your initial appointment?

What do you think will be your greatest benefit from orthodontic treatment?

Parents: Please complete the following questions:

Why did you decide to see an orthodontist and what made you choose our office?

What are concerns?

What expectations do you have from orthodontic treatment?

What questions would you like to have answered at your initial appointment.

Thank you.