

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 _____ Relationship 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	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pains	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nerve or Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Blood Vessel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Any type)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Herpes (Any type)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>

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 patient 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 _____

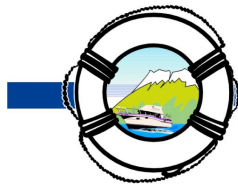
- Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment _____

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?

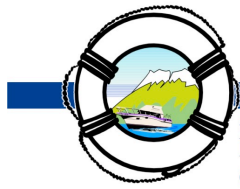
- Straighten the front teeth - upper / lower
- Straighten the back teeth - upper / lower
- Make the upper front teeth longer / shorter
- Move upper teeth - forward / backward
- Move lower teeth - forward / backward
- Make the line of the upper front teeth more level
- Move the midline of the upper / 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.