Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

Canales ORTHODONTICS

GARDENDALE 305 MITCHELL HILL RD. | GARDENDALE, AL 35071 · (205) 631-6033
ALABASTER 100 SOUTH COLONIAL DR. SUITE 800 | ALABASTER, AL 35007 · (205) 621-1111

Patient Information

NAME _____ PREFERRED NAME _____ GENDER _____

BIRTHDATE _____ AGE _____ GRADE _____ SCHOOL ATTENDS _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO TODAY'S APPOINTMENT _____

WHO HAS LEGAL CUSTODY OF PATIENT? _____

NAME OF SIBLINGS & AGES _____

HAVE WE TREATED ANY FAMILY MEMBERS? IF YES, WHO? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party

☐ MARRIED ☐ DOMESTIC PARTNERSHIP ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

PARENT/GUARDIAN NAME _____ PARENT/GUARDIAN NAME _____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ DATE OF BIRTH _____

ADDRESS _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

HOW LONG AT THIS ADDRESS? _____ HOW LONG AT THIS ADDRESS? _____

CELL PHONE _____ CELL PHONE _____

WORK PHONE _____ WORK PHONE _____

EMPLOYER _____ YEARS EMPLOYED _____ EMPLOYER _____ YEARS EMPLOYED _____

OCCUPATION _____ OCCUPATION _____

EMAIL _____ EMAIL _____

Primary Insurance Information

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID/SSN _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Secondary Insurance Information

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

EMPLOYER/GROUP NAME _____ GROUP NUMBER _____

SUBSCRIBER/EMPLOYEE _____ SUBSCRIBER ID/SSN _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

Please take a moment to complete the reverse side of this form.

PLEASE READ: We are passionate about our mission to give everyone a great smile. Please help us help you and your child by letting us know of any delayed development, social disabilities, ADD or ADHD, Bipolar, Autism, etc. _____

Medical History

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

	Y	N
1. IS THE PATIENT UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAS THE PATIENT BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS?	☐	☐
3. IS THE PATIENT TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S)?		
4. DOES THE PATIENT USE TOBACCO?	☐	☐
5. IS THE PATIENT ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS?	☐	☐
IF YES, WHAT?		
6. FEMALES ONLY:		
A. HAS MENSTRUATION BEGUN? IF YES, DATE: _____	☐	☐
B. IS THE PATIENT PREGNANT, OR THINK THEY MAY BE?	☐	☐
7. HAS THE PATIENT REACHED PUBERTY?	☐	☐

	Y	N
8. HAS THE PATIENT EVER BEEN EVALUATED FOR AIRWAY OBSTRUCTION AND/OR SLEEP APNEA?	☐	☐
9. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS?		
IF YES, SPECIFY _____	☐	☐

10. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE	☐
MIGRAINES	☐	ANEMIA	☐
DIABETES/GLAUCOMA	☐	CANCER	☐
RHEUMATIC FEVER	☐	JOINT REPLACEMENT/IMPLANT	☐
AIDS OR HIV INFECTION	☐	HEPATITIS/JAUNDICE	☐
CARDIAC PACEMAKER	☐	STOMACH TROUBLES/ULCERS	☐
ASTHMA (INHALER)	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STROKE	☐
THYROID PROBLEM	☐	RADIATION THERAPY	☐
HIGH/LOW BLOOD PRESSURE	☐	RESPIRATORY PROBLEMS	☐
HEART TROUBLE	☐	BONE DISORDER	☐
EPILEPSY/CONVULSIONS	☐	OSTEOPENIA/OSTEOPOROSIS	☐
TAKING MEDICATION:	☐	REMOVAL OF ADENOIDS/TONSILS	☐

IF SO, SPECIFY: _____

Dental History

DENTIST _____

DATE OF LAST CLEANING _____

	Y	N
1. IS THE PATIENT ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT?	☐	☐
2. DOES THE PATIENT REQUIRE PREMEDICATION FOR DENTAL TREATMENT?	☐	☐
3. DOES THE PATIENT FEEL PAIN TO ANY OF THEIR TEETH?	☐	☐
4. DOES THE PATIENT HAVE SORES OR LUMPS IN OR NEAR MOUTH?	☐	☐
5. HAS THE PATIENT HAD ANY HEAD, NECK, OR JAW INJURIES?	☐	☐
IF YES, PLEASE DESCRIBE:		
6. DOES THE PATIENT HAVE ANY ONGOING JAW PROBLEMS WITH:		
A. CHRONIC CLICKING OR POPPING?	☐	☐
B. PAIN?	☐	☐
C. DIFFICULTY OPENING OR CLOSING?	☐	☐
D. DIFFICULTY IN CHEWING?	☐	☐
7. DOES THE PATIENT CLENCH OR GRIND THEIR TEETH?	☐	☐
8. DOES THE PATIENT BITE THEIR LIPS OR CHEEKS FREQUENTLY?	☐	☐
9. HAS THE PATIENT EVER HAD SPEECH THERAPY?	☐	☐
IF YES, PLEASE DESCRIBE:		

	Y	N
11. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED?	☐	☐
IF YES, PLEASE DESCRIBE:		
12. HAS THE PATIENT EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH?	☐	☐
13. DOES THE PATIENT HAVE ANY OF THE FOLLOWING ORAL HABITS:		
A. NAIL BITING?	☐	☐
B. THUMB SUCKING?	☐	☐
C. TONGUE THRUST WHILE SWALLOWING?	☐	☐
D. MOUTH BREATHING?	☐	☐

14. HOW MANY TIMES A DAY DOES THE PATIENT BRUSH? _____

15. **PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH THE PATIENT IS SEEKING TREATMENT:**

CROWDING	☐	**MISSING TEETH**	☐
EXTRA SPACE	☐	**EXTRA PERMANENT TEETH**	☐
TEETH STICK OUT TOO FAR	☐	**TEETH ERUPTING IN THE WRONG POSITION**	☐
TMJ PROBLEMS	☐		
POOR BITE RELATIONSHIP	☐	**OTHER:** _____	

	Y	N
16. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE?	☐	☐
IF SO, WHEN AND BY WHOM?		

Please list who we can share information with:

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE **CANALES** ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) _____ DATE _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____