BOZEK
ORTHODONTICS

CONSULTATION QUESTIONAIRE

Welcome to our office. The following information is requested to enable us to provide you with an accurate orthodontic evaluation during your initial examination. In order for us to thoroughly diagnose any condition, we must have accurate background and health information. This information is confidential and will be used responsibly as per our privacy protocol.

Date: _____

Patient (Please Print or Type Directly)

Name: _____ Sex Female ☐ Male ☐ Birth date: _____Age:_____

Address: _____

Home Tel: _____Cell: _____Business #:_____Ext:_____

Email: _____ Appointment Email Reminders Yes ☐ No ☐

School:_____Grade:___ Patient Lives With: _____

Dentist: _____ Physician: _____ Orthodontic Insurance Yes ☐ No ☐ Dual ☐

Person responsible for account if different from above

Name: _____ Relationship (to patient): _____

Address: _____

Home Tel: _____Cell: _____Business #:_____ext: _____

Email: _____ Appointment Email Reminders Yes ☐ No ☐

Other Responsible Party (if different from above)

Name: _____ Relationship (to patient): _____

Address: _____

Home Tel: _____Cell: _____Business #:_____ext: _____

Email: _____ Appointment Email Reminders Yes ☐ No ☐

Whom may we thank for referring you to our office?

Patient ☐ Name: _____Friend ☐ Name: _____ Dentist ☐ Name: _____

Names of other family members who have been seen at our office: _____

In order to provide the best possible care for our patients, we would appreciate your accurate completion of the following questionnaire.

Yes	No	Medical History
____	____	Is the patient in good general health? When was the last medical check-up or visit to a physician? What was the reason for this visit? _____
____	____	Has there been a change in general health in the past year?
____	____	Is there currently treatment ongoing for any medical condition or has treatment been provided in the last year? Please provide reason: _____
____	____	Is there a history of having been hospitalized for any serious conditions or operations? Please specify: _____
____	____	Is there currently a need for medications or non prescription drugs of any kind? If yes, please specify: _____
____	____	Allergies or drug sensitivities: _____

Yes	No	
____	____	Have you ever taken **bisphosphonates**, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid or Zometa? _____
____	____	Any developmental, hereditary or behavioural concerns? _____
____	____	For women only – are you pregnant? And if so, when is the expected delivery date? _____

Have you ever had or been treated for (Please Circle):

Cancer	Rheunmatic fever	Blood Pressure	Thyroid disorder	Anemia	HIV/A.I.D.S
Asthma	Stomach Disorder	Heart trouble	Headaches	Epilepsy	Other S.T.D's
Sinusitis	Liver Disease	Joint problems	Kidney Disease	Hay Fever	Adenoids/Tonsils
Diabetes	Blood disorder	Tuberculosis	Bleeding Disorder	Hepatitis	Endocrine disorder

____ ____ Is there anything else we should know about your medical history? _____

_____

_____

Yes	No	**Dental History**
____	____	When was your last dental visit? _____
____	____	Do you regularly brush your teeth?
____	____	Do you regularly floss your teeth?
____	____	Do you see a dentist regularly?
____	____	Do any of your teeth ache?
____	____	Have you ever been advised to take antibiotics before dental appointments?
____	____	Do your gums bleed when brushing?
____	____	Do you have any pain when chewing?
____	____	Do you have any TMJ symptoms? (i.e. clicking, pain, popping) in the jaw joint?

Yes	No	**Orthodontic**

What are you hoping to accomplish with orthodontic treatment? _____

_____

____	____	Is there a history in your family of irregular or missing teeth?
____	____	Have you or other family members had orthodontic treatment?
____	____	Is the orthodontic problem obvious to the patient?
____	____	Is the patient satisfied with the appearance of their teeth?
____	____	Has there been a finger or thumb sucking habit - ongoing/in the past?
____	____	Has there been any accidents involving the teeth/jaw/nose?
____	____	Has the patient had any teeth extracted by the dentist?
____	____	Have there been any previous orthodontic consultations?

Any orthodontic fears or concerns? _____

_____

As a part of Canada's PIPEDA (Personal Information Protection and Electronic Document Act) Bozek Orthodontics complies with National and Provincial privacy legislation, the standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law. Privacy of your personal information is an important part of our office policies. We are committed to collecting, using and disclosing you personal information responsibly and you may ask at anytime to see our privacy protocol and speak to our privacy officer.

Permission Granted _____

(PARENT/GUARDIAN SIGNATURE)

To the best of my knowledge,

The above information is correct: _____ _____

(SIGNATURE) (DATE