BOZEK ORTHODONTICS

The teeth-straightening specialists

Burlington Office
4300 Upper Middle Rd. Unit 5
Burlington, ON L7M 4P6
905.331.7700

Waterdown Office
145 Hamilton St.,
Waterdown, ON L8B 0Y7
905.689.7314

Patient Information

First Name _____ Last Name _____ Gender _____ Birth date _____

Street Address _____ Apt. _____ City _____ Postal code _____

Home Phone _____ Cell Phone _____

Email Address _____

Name of Dentist _____ Name of Family Doctor _____

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

Do you know anyone in our practice (if yes please let us know who)? _____

What are your main goals for orthodontic treatment? _____

Responsible Party (if applicable)

Name _____ Relationship to patient _____

Street Address _____ Apt. _____ City _____ Postal code _____

Home Phone _____ Cell Phone _____

Email Address _____

Do you have an insurance plan that covers orthodontic treatment (Please see our insurance checklist questionnaire.)

☐ Yes - Please see our insurance checklist questionnaire. ☐ No

Other Responsible Party (if applicable)

Name _____ Relationship to patient _____

Street Address _____ Apt. _____ City _____ Postal code _____

Home Phone _____ Cell Phone _____

Email Address _____

Do you have an insurance plan that covers orthodontic treatment?

☐ Yes - Please see our insurance checklist questionnaire. ☐ No

Medical History

Any current or previous medical conditions? _____

Which conditions apply?

☐ Arthritis ☐ Asthma ☐ Autism ☐ Bleeding disorders ☐ Cancer

☐ Diabetes ☐ Fainting ☐ Heart Defect ☐ Heart Disease ☐ Hepatitis A/B/C ☐ High blood pressure

☐ HIV/AIDS ☐ Kidney Disease ☐ Lung Disease ☐ Sleep Apnea/ Snoring ☐ Migraines/Chronic Headaches ☐ Other

Other medical conditions not listed above _____

Medical History (continued)

Are you pregnant? (women only) ☐ Yes ☐ No

Are you currently under medical treatment? ☐ Yes ☐ No Treatment details

Are you currently taking any medications? ☐ Yes ☐ No Medication details

Do you require antibiotics before your dental work? ☐ Yes ☐ No

Have you ever taken medications for osteoporosis? ☐ Yes ☐ No Name of drug Are you currently on this medication? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No Please list

Have tonsils and/or adenoids been removed? ☐ Yes ☐ No At what age?

Are there any mental health issues? ☐ Yes ☐ No Description of mental health issues

Dental History

Have you ever had any trauma to the face, mouth or teeth? ☐ Yes ☐ No

Have there been dental x-rays taken within the last 12 months? ☐ Yes ☐ No

Do you see a dentist regularly? ☐ Yes ☐ No Date of last visit

Have you ever had any trauma to the face, mouth or teeth? ☐ Yes ☐ No Please provide details of the injury

Any finger or thumb habits? ☐ Yes ☐ No

Do you get frequent canker sores? ☐ Yes ☐ No

Do you have any pain, clicking, and/or popping noises in your jaw? ☐ Yes ☐ No

Have you been treated for this problem? ☐ Yes ☐ No

Have you ever seen a periodontist (gum specialist) ☐ Yes ☐ No What was the doctors name?

Have you had previous extractions (baby teeth, permanent teeth, wisdom teeth)? ☐ Yes ☐ No

Are you a mouth breather? ☐ Yes ☐ No

Has there been previous orthodontic treatment or consultation? ☐ Yes ☐ No

Have any of your family members had orthodontics? ☐ Yes ☐ No Please list

By sharing your email with Bozek Orthodontics you agree to receive emails and texts from us about appointments, insurance, tax receipts, and other practice information, and understand that you can opt out at any time. Your email and personal information will not be shared with 3rd parties at any time.

☐ Yes ☐ No

I hereby give Bozek Orthodontics permission to release information concerning my dental and/or orthodontic health to my family physician, dentist or any other dental specialists as is deemed necessary. This information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

☐ Agree

By signing below,you are agreeing to all conditions and terms that apply, and attesting to the accuracy of the answers given.

PATIENT SIGNATURE

DATE