Patient's identity **(please correct if necessary)** **File number 0**

Joe Smith Dentist: Dr. ____
00 Street
Dieppe, NB
E1G 4S4

Tel.: (506) 000-0000 Joe Smith (506) 000-0000
Email: info@drhuard.ca ( ) -

Date of birth: 00-00-0000 (49,9 years on 2014-06-10)

General Questionnaire

Briefly describe the reason for your visit.

_____
_____
_____
_____

Who observed the need for orthodontic therapy? □ Parents □ Patient
□ Dentist □ Other_____

What is the patient's main concern? □ Aesthetic □ Function □ Prevention of future problems
□ Pain □ Other_____

	Yes	No
Does the patient have a relative with a similar facial or dental problem?	□	□
If yes, how is the person related:_____		
Has any other family member undergone orthodontic therapy?	□	□
If yes, how is(are) the person(s) related: _____		
Is the patient aware of his/her dental problem?	□	□
Is the patient concerned by the appearance of his/her teeth?	□	□
Does the patient sometimes receive unpleasant comments about the appearance of his/her teeth or face?	□	□

Tell us how you got here:

□ my dentist recommended me:

□ to see an orthodontist

□ to see Dr. Huard for a consultation

□ a family member or a friend recommended me Dr. Huard's clinic:_____

□ found Dr Huard's clinic after a search for an orthodontist □ on the Web □ in the Yellow Pages

□ saw Dr Huard's name in an advertisement

□ other:_____

Medical history

Has the patient ever suffered, or his s/he currently suffering, from any of the following:

	Yes	No		Yes	No
Anemia, blood disorders	☐	☐	Frequent headaches	☐	☐
Arthritis	☐	☐	Earache	☐	☐
Asthma	☐	☐	Blood pressure ☐ high ☐ low	☐	☐
Endocrine disorders	☐	☐	Digestive problems	☐	☐
Diabetes	☐	☐	Lung problems	☐	☐
Epilepsy	☐	☐	Tuberculosis	☐	☐
Fainting	☐	☐	Frequent colds, sinusitis	☐	☐
Rheumatic fever	☐	☐	Extended bleeding	☐	☐
Hepatitis, liver disorders	☐	☐	Cardiac disorders	☐	☐
Hypoglycemia	☐	☐	Nervous or emotional problems	☐	☐
Skin diseases	☐	☐	Kidney disorders	☐	☐
Bone diseases	☐	☐	Thyroid disorders	☐	☐
Immune system diseases	☐	☐	Other, please specify_____		

Have the patient's tonsils been removed? ☐ ☐

Have the patient's adenoids been removed? ☐ ☐

Does the patient have a deviation of the nasal septum? ☐ ☐

Has the patient ever undergone radiation therapy or chemotherapy? ☐ ☐

Is the patient HIV-positive? ☐ ☐

Has the patient received medical treatment in the last 2 years? ☐ ☐

Does the patient have any allergies (medication, food or other)? ☐ ☐

If yes, what are they? _____

Is the patient currently being treated - followed by a doctor? ☐ ☐

If yes, why?_____

Attending physician_____

Is the patient currently taking bisphosphonate medication? (Fosamax, Actonel, Boniva, Zometa, Aredia, Xgeva (denosumab) etc.) ☐ ☐

If yes, orally or intravenously? _____ since when: _____

Is the patient currently taking any other medication? ☐ ☐

If yes, which? _____

Has the patient ever undergone major surgery? ☐ ☐

If yes, why? _____

Has the patient ever suffered a trauma to the face, teeth, neck or jaw (accident or other reason) ? ☐ ☐

Adolescent only:

Is the patient currently in an active growth period? ☐ ☐

Does the patient appear to have reached puberty? ☐ ☐

Girls only: Has the patient begun menstruating? If yes, since when: _____ ☐ ☐

Women only: Are you pregnant? ☐ ☐

Dental history

Date of last checkup: _____ Date of last dental x-rays: _____

Frequency of visits to the dentist: _____ Number of daily brushings:_____

The patient's dental hygiene is considered to be: □ Excellent □ Good □ Average □ Poor

Has the patient ever received any of the following treatments:

	Yes	No		Yes	No		Yes	No
Tooth extraction	□	□	Sealing of pits or cracks	□	□	Grinding of occlusion	□	□
Jaw surgery	□	□	Crown, bridge, partial	□	□	Orthodontic therapy	□	□
Root canal	□	□	Gum treatment	□	□	Speech therapy	□	□
Filling	□	□	Therapy with a nightguard	□	□	Aesthetic treatment		
Other (specify): _____						(veneer, bleaching, etc.)	□	□

Does the patient:

	Yes	No		Yes	No
Suck his/her thumb	□	□	Experience pain or cracking		
Bite his/her nails	□	□	in the jaw when chewing	□	□
Bite his/her cheeks	□	□	Avoid food he/she cannot chew	□	□
Grind his/her teeth at night	□	□	Have a speech impediment	□	□
Breathe through the mouth at night	□	□	See a speech therapist, now or in the past	□	□
Have recent changes in the position			Play a musical instrument	□	□
of his/her teeth	□	□	if yes, which one_____		
Have loose teeth	□	□			
Have sensitive teeth	□	□			

I understand that Dr. Huard could recommend a referral to a Specialist, for a treatment or consultation. I understand that to facilitate my consultation with this Specialist, there will be communications between Dre Huard, my dentist and the Specialist. I understand that the Specialist and my dentist may require information from my dental records, including, but not limited to x-rays, study models, etc. I hereby authorize Dr. Huard to release all reasonable and pertinent information contained in my dental records that Dr. Huard feels will be of assistance to the Specialist or my dentist or that is specifically requested by the Specialist or my dentist. I hereby also authorize the Specialist to communicate, discuss and share information from my consultation with my dentist and Dr.Huard, including but not limited to x-rays, study models, etc.

_____ _____

Patient's signature or Guardian

Date

_____