Orthodontic Patient Information

ATLANTIC DENTAL

The following information is requested to enable us to give you the best consideration of your orthodontic program during your initial examination in our office. In order for Dr. Hamlyn to thoroughly diagnose any condition, she must have accurate background and health information on which to base her decisions. This information, important for our records and your health, is confidential.

Last Name _____ First Name _____ Date of Birth _____

Address _____ City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Insurance Company _____ Policy/Plan Number _____ Certificate/Identification Number _____

Plan holder's name _____ Plan holder's date of birth _____ Plan holder's employer _____

Chief complaint about your smile _____

Have you previously received orthodontic treatment? Y / N

Have you ever received an injury to your head or face? Y / N

Are you currently receiving regular dental care? (cleanings, exams…) Y / N

Are you currently taking any medications? If yes, please list: _____

Do you have any allergies? If yes, please list: _____

Please circle any of the following that apply to you, past or present:

Asthma	Dizziness	Liver Disorder
Anemia	Epilepsy	Lung Disease
Blood Disease	Fainting	Migraines
Bone Disorder	Head or Neck Pain	Pain when chewing
Cancer	Heart Disease	Other:
Diabetes	Jaw Clicking	

Comments: _____

Consent for Treatment: I consent to the performing of dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures. I have reviewed the Privacy Statement for Patients that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Atlantic Dental Centre can collect, use and disclose my personal information as set out in the office's privacy policy.

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Signature of patient or parent/guardian **Date**

Electronic Claims Submission Signature on File (CDAnet): I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

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Signature of patient or parent/guardian **Date**