Dr. Christopher T. Clarke
DMD MSc FRCD(C)
Certified Specialist in Orthodontics
C.T. Clarke Dentistry Professional Corporation

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PATIENT REGISTRATION

Today's Date _____ Gender: M F Age _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
STREET / BOX CITY PROVINCE POSTAL CODE

Home Phone #_____ Work #_____ Cell #_____

Date of Birth _____ Date of last dental check-up_____
DAY / MONTH / YEAR DAY / MONTH / YEAR

Family Dentist _____
NAME ADDRESS

Who may we thank for referring you? _____ Email Address _____

Have any family members visited our office? If yes, whom? _____

For patient's younger than 18 years of age:

Father's Name _____ Phone (H)_____(W)_____
LAST FIRST MIDDLE

Address _____ ☐ Same as above
STREET / BOX CITY PROVINCE POSTAL CODE

Mother's Name _____ Phone (H) _____(W) _____
LAST FIRST MIDDLE

Address _____ ☐ Same as above
STREET / BOX CITY PROVINCE POSTAL CODE

Person(s) with patient at exam _____ Relationship to patient _____

Person Financially Responsible for Account _____

The following information is required to enable us to provide you with the best possible orthodontic care. All information is strictly private, and is protected by doctor-patient confidentiality. The orthodontist will review the questions and explain any that you do not understand. Please fill in the entire form.

MEDICAL / DENTAL HISTORY

Family Physician _____ Date of last physical _____ General Health _____
DAY / MONTH / YEAR

Is patient under a physician's care? Yes ☐ No ☐ If so, for what? _____

List any medications now being taken: (None ☐)_____

List any allergies, drug or latex sensitivity: _____

Does patient vomit, gag or faint easily? Yes ☐ No ☐ If yes, please explain _____

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Does the patient require Antibiotic Pre-Medications for routine dental procedures? Yes ☐ No ☐ Explain _____

Have any teeth been injured due to accidents or blows to the mouth? Yes ☐ No ☐ If yes, please explain to the orthodontist in detail.

Has the patient received/been requested to receive speech therapy? Yes ☐ No ☐ If yes, please explain to the orthodontist in detail.

Has patient had previous orthodontic consultation or treatment? Yes ☐ No ☐
If yes, please specify _____
Dates of Treatment _____ Orthodontist _____

Does the patient experience headaches or neck aches, especially under stress?	Yes ☐	Sometimes ☐	No ☐
Does the patient grind or clench teeth?	Yes ☐	Sometimes ☐	No ☐
Has the patient had any jaw or head injuries?	Yes ☐		No ☐
Does the patient experience any clicking, popping or pain while chewing or yawning?	Yes ☐	Sometimes ☐	No ☐
Has the patient experienced any episodes of jaws locking in the open or closed positions?	Yes ☐	Sometimes ☐	No ☐
Has the patient ever consulted anyone regarding a jaw problem?	Yes ☐	Sometimes ☐	No ☐

The following habits are of interest to the orthodontist.

Thumb sucking	Yes ☐	No ☐	Until age _____
Finger sucking	Yes ☐	No ☐	Until age _____
Lip biting or sucking	Yes ☐	No ☐	
Nail biting	Yes ☐	No ☐	
Tongue thrusting	Yes ☐	No ☐	
Smoking or tobacco use.	Yes ☐	No ☐	Amount and frequency _____
Other habits	Yes ☐	No ☐	Please specify _____

Has patient been diagnosed or treated for any of the following:

Abnormal Blood Pressure	Yes ☐	No ☐	Bone Disorders	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
AIDS / HIV positive	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Immune Dysfunction	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Endocrine Problems	Yes ☐	No ☐	Lung Disorders	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Epilepsy / Seizures	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐	Other	Yes ☐	No ☐
Blood Disorders	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐	Explain _____		

For women only: Are you breast-feeding or pregnant? Yes ☐ No ☐ If pregnant, what is the expected delivery date? _____

Patient's attitude toward teeth, face and orthodontic treatment:

Brushing teeth: Number of times per day _____
Dental check-ups: Twice yearly ☐ Once yearly ☐ Only if urgent ☐ Never ☐
Please rate your perception of the orthodontic problem (circle): Very severe – 10 – 9 – 8 – 7 – 6 – 5 – 4 – 3 – 2 – 1 – No Problem
Patient's interest in orthodontic treatment: ☐ Patient wants treatment ☐ Treatment if necessary
☐ Unwilling but agrees ☐ Uncooperative

Is there any reason the patient may have problems with orthodontic treatment?	Yes ☐	No ☐
Is the patient/parent aware that appointments may infringe on school/work time?	Yes ☐	No ☐

What is the primary orthodontic concern? _____

What is expected from orthodontic treatment? _____

Additional comments _____

Name of the person completing this form _____ Signature _____
PRINT SIGN

REVIEWED BY ORTHODONTIST _____ DATE _____