ACP ORTHODONTICS

DR. CONNY ATHANASOPOULOS

WELCOME TO OUR PRACTICE!

To become better acquainted and to offer you the best possible care, we ask that you complete both pages of this Patient Questionnaire.

All information will be kept in strict confidence.

Patient Information:

Name: _____

Birthdate: ____ / ____ / ____ ☐ Male ☐ Female
M D Y

Address: _____

_____

Home Phone: (___) _____
Work Phone: (___) _____
Cell Phone: (___) _____
Email: _____

Other Family members seen by Dr. Conny:

_____

_____

Insurance Information:

Our office charges the Patient or Responsible Party directly for all services rendered. We will complete the necessary forms for your submission to receive the amount of orthodontic coverage to which you are entitled under your policy.

Do you have orthodontic coverage? ☐ Yes ☐ No ☐ Unsure

1. Subscriber's Name: _____
Birthdate: ____ / ____ / ____
M D Y

Insurance Company & Address: _____

_____

Policy/Contract No.: _____
Identification/Certificate No.: _____

2. Subscriber's Name: _____
Birthdate: ____ / ____ / ____
M D Y

Insurance Company & Address: _____

_____

Policy/Contract No.: _____
Identification/Certificate No.: _____

Responsible Party Information: (If patient is under 18)

Parents Marital Status (please circle)

Single Widowed Married Divorced Separated Partnered

Mother: (or ☐ Step-Mother ☐ Guardian)
Name: _____
Birthdate: _____ / _____ / _____
M D Y

Address: (if not same as patient)

_____

_____

Home Phone: (___) _____
Work Phone: (___) _____
Cell Phone: (___) _____
Email: _____

Father: (or ☐ Step-Father ☐ Guardian)
Name: _____
Birthdate: _____ / _____ / _____
M D Y

Address: (if not same as patient)

_____

_____

Home Phone: (___) _____
Work Phone: (___) _____
Cell Phone: (___) _____
Email: _____

Person(s) Responsible for payments on Account:

Name: _____ Relation: _____
Name: _____ Relation: _____

Person Responsible for making Appointments:

Name: _____ Relation: _____

Do you receive funding through:

- ☐ First Canadian Health/Status
- ☐ Cleft Lip/Palate Clinic
- ☐ Manitoba Public Insurance

Medical History:

Physician's Name: _____

Are you being treated for any medical condition at the present or have been treated within the past year?

☐ Yes ☐ No

If so, why?_____

When was your last medical check-up? _____

Has there been any change in your general health in the past year? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ Yes ☐ No

If yes, please list:_____

Does the patient have/has had any of the following diseases or medical problems:

Y N Abnormal bleeding
Y N AIDS/HIV
Y N Alcohol/Drug Use
Y N Anemia
Y N Arthritis
Y N Artificial Heart Valve/Joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Chest Pain/Angina
Y N Cold Sores
Y N Colitis
Y N Congenital Heart Defect
Y N Cystic Fibrosis
Y N Diabetes
Y N Difficulty Breathing
Y N Emotional Problems
Y N Emphysema
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Surgery
Y N Habits – nail biting/lip biting/ thumb sucking
Y N Heart Murmur
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N Hospitalized
Y N Infection of the Heart (Infective Endocarditis)
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Leukemia
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis Medications
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic Fever
Y N Seizures (Epilepsy)
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis (TB)
Y N Stomach Ulcers
Y N Venereal Disease

Are there any conditions or diseases not listed above that you have or have had? ☐ Yes ☐ No If so, what? _____

_____

Are there any diseases or medical problems that run in your family? (ex: Diabetes, cancer or heart disease?) ☐ Yes ☐ No

If yes, please explain: _____

Do you smoke or chew tobacco products? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No (please circle)

Medications: Penicillin, Ibuprofen, Codeine

Latex/Rubber Products

Other: Jewelry/Metal/Seasonal, etc.

Dental History:

Dentist's Name: _____

What is the reason for your orthodontic consultation?

_____

_____

Does any other family member have a similar bite/ problem?

☐ Yes ☐ No Who? _____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Are you nervous during dental treatment? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have speech problems? ☐ Yes ☐ No

Do you have wisdom teeth? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to your: (please circle)
Mouth Teeth Chin

Do you breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While awake? While asleep?

Do you have/have had problems with your TMJ (jaw joints)? ☐ Yes ☐ No

Please explain: _____

_____

Are you self-conscious of your teeth/smile? ☐ Yes ☐ No

For women only: Are you pregnant? ☐ Yes ☐ No

Our office is committed to maintaining the infection control guidelines set out by the Canadian & Manitoba Dental Associations.

Patient Consent:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strict confidence and that it is my responsibility to inform this office of any changes in address and my medical/dental status.

_____ _____

Signature Patient/Parent/Guardian Date

OFFICE USE ONLY: I verbally reviewed the entire chart, including the medical/dental information with the patient/parent named herein.

Staff Initials: _____ Date: _____

Comments:_____