embrace ORTHODONTICS

New Patient Form

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902-817-6453 hello@embracelifesmiling.com

Please complete this form and bring it to your first visit, or fill it in online at embracelifesmiling.com. It takes a few minutes. If you get stuck on anything, call us on 902-817-6453 and we will happily help.

How you found us

- [ ] My dentist referred me
- [ ] My dental insurance
- [ ] Internet search
- [ ] A staff member
- [ ] Friend or family
- [ ] Advertisement
- [ ] Social media

If a dentist referred you, or you chose "other", who or what? (optional)

Patient details

Patient full name

Preferred name (optional)

Date of birth

Gender

- [ ] Female
- [ ] Male
- [ ] Another
- [ ] Prefer not to say

Street address (optional)

City or town (optional)

Province (optional)

Postal code (optional)

Student status

- [ ] Full-time student
- [ ] Part-time student
- [ ] Not a student

School (optional)

Grade (optional)

Number of siblings (optional)

Family members already treated at Embrace Orthodontics (optional)

Hobbies, interests and sports (optional)

Parent or guardian, and who is responsible for the account

Parent, guardian or responsible party (if the patient is under 18)

Relationship to patient

☐ Self ☐ Mother ☐ Father ☐ Guardian ☐ Other

Phone

Second phone (optional)

Email

☐ I am the person financially responsible for this account.

Your dental care

Family dentist (optional)

Last dental visit

☐ Less than 6 months ago ☐ 6 to 12 months ago ☐ Over a year ago ☐ Never

General physical health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current medications (optional)

☐ The patient is currently under a physician's care.

Physician name (if under a physician's care)

Dental and orthodontic history

Please tick anything that applies to the patient.

- [ ] Had a previous orthodontic consult
- [ ] Currently in dental pain
- [ ] Injury to the face, mouth, teeth or jaw
- [ ] Jaw clicking, popping or pain (TMJ or TMD)
- [ ] Pregnant
- [ ] Apprehensive at dental visits
- [ ] Needs premedication before dental work
- [ ] Tonsils or adenoids removed
- [ ] May have missing adult teeth
- [ ] Taking birth control

Medical history

We ask about health only so we can plan care safely, and it is used only for that. Please tick anything that applies.

Dental hygiene

- [ ] Brushes daily
- [ ] Flosses daily
- [ ] Gums bleed
- [ ] Fluoride treatments

Oral habits

- [ ] Clenching or grinding
- [ ] Lip biting or sucking
- [ ] Mouth breathing
- [ ] Snoring during sleep
- [ ] Pacifier or bottle
- [ ] Speech concerns
- [ ] Thumb or finger sucking
- [ ] Tongue thrusting

Allergies

- [ ] Aspirin
- [ ] Codeine
- [ ] Dental anesthetic
- [ ] Erythromycin
- [ ] Latex
- [ ] Metal or jewellery
- [ ] Penicillin
- [ ] Plastic

Other allergies (optional)

Bone-strengthening medication (bisphosphonates), now or in the past

- [ ] Fosamax
- [ ] Actonel
- [ ] Boniva
- [ ] Prolia
- [ ] Reclast

Medical conditions

- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma or hay fever
- [ ] Bleeding disorder
- [ ] Bone disorder
- [ ] Cancer or tumour
- [ ] Chicken pox
- [ ] Chronic sinus problems
- [ ] Congenital heart defect
- [ ] Diabetes
- [ ] Epilepsy or seizures
- [ ] Gastrointestinal disorder
- [ ] Growth disorder
- [ ] Hearing impairment
- [ ] Heart murmur
- [ ] Heart problem
- [ ] Hepatitis
- [ ] Herpes
- [ ] High blood pressure
- [ ] HIV or AIDS
- [ ] Hives
- [ ] Kidney problems
- [ ] Liver problems
- [ ] Lupus
- [ ] Measles
- [ ] Mitral valve prolapse
- [ ] Mononucleosis
- [ ] Nervous disorder
- [ ] Pneumonia
- [ ] Radiation therapy
- [ ] Rheumatic fever
- [ ] Scarlet fever
- [ ] Skin rash
- [ ] Sleep apnea
- [ ] Recent surgery
- [ ] Tuberculosis

Anything else we should know (medications, conditions or allergies)

Insurance

- [ ] We have orthodontic or dental insurance.

Insurance carrier (optional)

Certificate or member ID (optional)

Policy holder name (optional)

Policy holder date of birth (optional)

Policy holder relationship to patient (optional)

Group or employer (optional)

Group number (optional)

Subscriber or member number (optional)

Second insurance, if any

Second insurance carrier (optional)

Second member number (optional)

What matters most to you

This helps Dr. Catherine McLeod tailor your options. Rate how important each is to you.

	Not important	Slightly important	Important	Very important	Most important
Length of treatment	☐	☐	☐	☐	☐
Comfort during treatment	☐	☐	☐	☐	☐
Treatment using the latest technology	☐	☐	☐	☐	☐
Clear or invisible treatment	☐	☐	☐	☐	☐
A low down payment	☐	☐	☐	☐	☐
A low monthly payment	☐	☐	☐	☐	☐
Quality of treatment	☐	☐	☐	☐	☐
Starting treatment in the next month	☐	☐	☐	☐	☐

What brings you in

What would you most like us to help with?

Consent

- ☐ I have read and consent to the privacy policy, which explains how Embrace Orthodontics collects, uses and protects my personal information.
- ☐ I am happy for Embrace Orthodontics to contact me by phone, text or email about appointments and care. I understand text and email are not fully secure.
- ☐ I am happy to receive occasional emails or texts about practice news, events and offers. (optional)
- ☐ The information here is complete and correct to the best of my knowledge. I will let the team know of any changes, and I authorize the release of relevant information to my insurer and to any other providers involved in my care.
- ☐ I give permission for photographs and records taken during care to be used for treatment, education and on Embrace Orthodontics' own channels. I can withdraw this in writing at any time. (optional)

Your name **Date**

Signature