ORTHODONTIC CENTRE IN MILTON

Dr. Lyndon Wong
D.D.S., CERT. ORTHO, FRCD(C)
Certified Specialist in Orthodontics

Patient Information (please complete in ink)

Name: Mr/Mrs/Ms ____________________ Date of Birth: __________ Gender: M / F
Last First Middle YY / MM / DD

Address: ____________________ Email: __________
Street City Postal Code

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Occupation: __________ Employer: __________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married

Who can we thank for referring you to our office? __________

Medical History

Name of Physician: __________

Address: __________

Yes	No	
☐	☐	Are you currently being treated for any medical conditions? List: __________
☐	☐	Are you currently taking any medications? List: __________
☐	☐	Do you have any allergies? List: __________
☐	☐	Do you have any allergies to medications? If yes, describe: __________
☐	☐	Have you ever had any serious illnesses? If yes, describe: __________
☐	☐	Have you ever been hospitalized or undergone any surgeries? __________
☐	☐	For women, are you pregnant or suspect that you might be? Anticipated due date: __________
☐	☐	Do you now or have you ever taken bisphosphenates (incl. Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid or Zometa)?

Have you had, or do you have any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Liver Disease	☐	☐	Nerve/Brain disease
☐	☐	Heart Murmur	☐	☐	Lung Disease	☐	☐	Seizures/Epilepsy
☐	☐	Heart/Valve disease	☐	☐	Asthma	☐	☐	Autism
☐	☐	Heart Attack/Stroke	☐	☐	Tuberculosis (TB)	☐	☐	Arthritis
☐	☐	Prosthetic Joint/Valve	☐	☐	Cancer/Radiation treatment	☐	☐	Bone disorders
☐	☐	High/Low Blood Pressure				☐	☐	Vision/Hearing problems
☐	☐	Blood disorder	☐	☐	Stomach ulcers	☐	☐	Sleep Apnea
☐	☐	Hemophilia	☐	☐	Herpes (any type)	☐	☐	Sinus Problems
☐	☐	HIV/AIDS	☐	☐	Skin disease (ie Eczema)	☐	☐	Other: __________
☐	☐	Diabetes	☐	☐	Migraine/headaches			

Please list any other significant information regarding your medical history:

____

____

____

Dental History

What is your primary concern about your teeth and smile?____

Dentist: ____________________________ Address: ____

Yes No

___ ___ Are you currently experiencing dental pain?

___ ___ Have you had previous orthodontics? When?____________________ Which Dr? __________________

___ ___ Have you ever injured your teeth or mouth? Describe: ____

___ ___ Do you have, or have you, experienced soreness/tightness/pain in jaw muscles?

___ ___ Do you have, or have you, experienced clicking/popping/grinding in your jaw joints?

___ ___ Do you have, or have you, experienced difficulty opening or closing your jaw?

___ ___ Have your jaws ever "locked"?

___ ___ Do you clench or grind your teeth?

___ ___ Do you have missing or extra permanent teeth?

How often do you brush and floss each day? Brush _____ times per day Floss _____ times per day

Dental Insurance Information

Primary Insurance Company: ____

Address: ____ Group/Plan Number: _________________________

Policy holder name: _________________________________

Secondary Insurance Company: ____

Address: ____ Group/Plan Number: _________________________

Policy holder name: _________________________________

I acknowledge that I read and understand the above medical and dental information and certify the above information is correct. If there are any changes to the above information, I will notify the office of any changes that occur. I also give my permission for Dr. Wong and his team to perform an initial orthodontic evaluation.

__________________________	____________________	______________	___________________________
Name	**Signature**	**Date**	**Dr. Lyndon Wong**