BLUNDELL ORTHODONTICS

Dr. Asef Karim
Certified Specialist in Orthodontics

NEW PATIENT MEDICAL HISTORY FORM

PERSONAL INFORMATION

Patient's Name:_____   Referred by: _____

Date of Birth: (MM/DD/YYYY) _____   Age: _____

Gender: M   F   NB

Home Address: _____   Postal Code: _____

Home Phone: _____   Business Phone: _____

Mobile Phone: _____   Carrier: _____

Email Address: _____

Preferred communication for reminders: Email   Phone   SMS/Text

Parent or Guardian's Name: _____

Parental Relationship: Married   Widowed   Separated   Divorced   Single   Common Law

Parent Occupation: _____

Person Responsible for the Account: _____

Patient's School: _____ Grade: _____

DENTAL INFORMATION

Do you have orthodontic insurance?   Yes   No

Insurance Name: _____ Percentage: _____ Financial Limit:_____

Group: _____ ID: _____

Patient's Dentist:_____ Last Cleaning Date: _____

Has the patient ever had orthodontic treatment before?   Yes   No

Have any family members had orthodontic treatment?   Yes   No

MEDICAL INFORMATION

Patient's Physician: _____

Do you have a history of or are you being treated for any of the following?

ADD/ADHD	AIDS	Allergies	Anemia	Anxiety	Arthritis
Asthma	Autism Spectrum	Bleeding	Cancer	COVID-19	Diabetes
Down's Syndrome	Emotional Disorder	Emphysema	Epilepsy	Eye Problems	Fainting
Heart	Hepatitis	High Blood Pressure	HIV	Jaundice	Learning/ Behaviourial Disorder
Lung Disease	Nervous Disorder	Sinus Pressure	Sleep Apnea	Stomach Problems	Stroke
Thyroid	Tuberculosis	Others	**None of the above**		

Y   N

Is general health good?

Are you taking any medications?

Do you have any allergic reactions?

Do you have a latex allergy?

Have you ever had an injury, surgery, or x-ray therapy on the head or jaws?

Any artificial joints, heart valves, pacemaker, or prosthetics?

WOMEN ONLY: Are you pregnant?

If you answered YES to any of the above, please comment below:

_____

I authorize Dr. Karim/Blundell Orthodontics team to carry out an examination (including orthodontic photos, digital photographs, digital xrays and 3D scan) on my dependent/myself. I understand that if I would like to have these records transferred there is a fee.
I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____   _____
SIGNATURE (Please sign/type your name)

Date