refine

ORTHODONTICS

Care as Unique as Your Smile

Dr. Julia Ng

Certified Specialist in Orthodontics
and Dentofacial Orthopedics

Patient Legal Name:____

Preferred Name:____

Birthdate:________________________ Age:_________ Gender: M / F
Month/Day/Year

Home
Address:____

City:__________________________________ Postal Code:_______________

Phone(Home):____________________ Phone (cell):______________________

Email:____

Patient School:____

Patient Sports/Hobbies:____

Name of parent or guardian (for patients under 19 yrs):____________________

Place of Employment:_______________________ Phone (Work):___________

Do you wish to be updated on news, rewards, contests and events happening in our office via email? Yes / No

106 - 2190 West Railway Street
Abbotsford, BC V2S 2E2
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refineorthodontics.ca

Referred by:____

Dentist:____

Please complete the following insurance information, if applicable:

Name of employer: ____________________________________

Name of insurance Co:____

Group, plan, or policy #:____

ID # or Certificate #.:___________________________ Dependent #:_________

Name of subscriber:_____________________

Birthdate of subscriber:_____________________ mm/dd/yyyy

Secondary Plan, if applicable:

Name of employer: ____________________________________

Name of insurance Co:____

Group, plan, or policy #:____

ID # or Certificate #.:___________________________ Dependent #:_________

Name of subscriber:_________________________

Birthdate of subscriber:_____________________ mm/dd/yyyy

I authorize Dr. Julia Ng to perform a complete orthodontic examination. Yes / No

I authorize Refine Orthodontics to send a copy of the treatment plan to my insurance company for preauthorization. Yes / No

I authorize Refine Orthodontics to correspond with my/my child's dental office.
Yes / No

Signature:___________________________________

Date:_________________________Month/Day/Year

Patient name:_________________________ Date:__________________________
Date of birth:_________________________
Form completed by:____________________________
Name of physician:_____________________________

Chief Complaint

Inherited and Congenital

Yes No Were there congenital anomalies present at birth (cleft lip/palate, etc)?
Yes No Is there anyone else in the family that has a similar dental condition?
Yes No Do you have siblings? ___________________________________
Yes No Have they (siblings) had treatment? ________________________

____

Environmental

Yes No Is there any history of asthma, hay fever, allergies?
Yes No Have the tonsils and adenoids been removed?
Yes No Were there any major falls, accidents, or operations to the head region?

Dental History

Yes No Have any primary (baby) or permanent (adult) teeth been removed?
Yes No Have you had any previous orthodontic treatment?
Yes No Have there been any accidents, falls, or blows to the teeth?

What dental treatments have you had in the past? Any root canals?
____

Most recent dental check-up?____

History of Habits

Yes No Thumb or finger sucking
Yes No Lip biting
Yes No Other mouth habits________________________
Started____________ Stopped_____________ How often____________

Patient Attitude

Yes No Would you wear braces for several years?
Yes No Would you cooperate by brushing, avoiding certain foods, and if needed, wearing elastics or other appliances?
Yes No Do you have activities that may interfere with appointments?

TMJ

Yes No Do you have difficulty or pain or both when opening your mouth (eg:yawn)?
Yes No Does your jaw get “stuck”,”locked” or “go out”?
Yes No Do you have difficulty/pain/both when chewing, talking, or using your jaws?
Yes No Are you aware of noises in the jaw joints?
Yes No Does your bite feel uncomfortable or unusual?
Yes No Do you have frequent headaches?
Yes No Have you had a recent injury to your head, neck or jaw?
Yes No Have you previously been treated for a jaw joint problem?

Medical History

Yes No Are you taking any medication or drugs at the present time?_____________

Have you ever had any serious illness such as (please circle):

Abnormal blood pressure	Diabetes	Liver disease
Anemia	Epilepsy	Lung or breathing problems
Arthritis	Heart murmur	Mental or nervous disorder
Blood disorder	Hepatitis	Rheumatic fever
Bone disorders	HIV	
Congenital Heart Defect	Kidney disease	

Other (please specify)____

Yes No Do you require antibiotics before you have dental work done?
Yes No Are you allergic to any foods or medication? If so, please list.

(Female Patients)
Yes No Has menstruation started?
Yes No Are you pregnant?
Yes No Have you ever taken oral bisphosphonate medication? (Fosomax, Actonel, Didrocal)?