Dr. Iris Kivity-Chandler
ORTHODONTIST
IKC Orthodontics

ORTHODONTIC INFORMATION

DATE: _____ PATIENT NAME: _____

ADDRESS: _____ APARTMENT #: _____

CITY: _____ POSTAL CODE: _____ AGE: _____ DATE OF BIRTH: _____

IF ADULT:

TEL.: HOME: _____ CELL: _____ WORK: _____

EMAIL: _____

IF MINOR:

PATIENT LIVES WITH: MOTHER_____ FATHER: _____ BOTH: _____ OTHER: _____

GUARDIAN #1 RELATIONSHIP TO PATIENT: _____ NAME: _____

BEST TELEPHONE CONTACT NUMBER: _____ PLEASE CIRCLE: HOME CELL WORK

EMAIL: _____

GUARDIAN #1 RELATIONSHIP TO PATIENT: _____ NAME: _____

BEST TELEPHONE CONTACT NUMBER: _____ PLEASE CIRCLE: HOME CELL WORK

EMAIL: _____

DENTIST NAME: _____ PHYSICIAN NAME: _____

REFERRED TO OUR OFFICE BY: _____

WHY ARE YOU INTERESTED IN ORTHODONTIC TREATMENT? _____

_____

DO YOU SUFFER FROM DENTAL ANXIETY? WHAT CAUSES IT? _____

CLICK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- □ _____ HEADACHES
- □ _____ HEARING PROBLEMS
- □ _____ EARACHES
- □ _____ EYE PROBLEMS
- □ _____ AUTOIMMUNE DISORDE F
- □ _____ EPILEPSY
- □ _____ ASTHEMA
- □ _____ KIDNEY DISEASE
- □ _____ DIABETES
- □ _____ HEART PROBLEMS
- □ _____ RHEUMATIC FEVER
- □ _____ PROLONGED BREATHING
- □ _____ HEPATITIS
- □ _____ HAY FEVER

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PLEASE CHECK THE APPROPRIATE SQUARE:

		Y	N
1.	Is the patient in good health?	☐	☐
2.	Does the patient have a history of major illness?	☐	☐
3.	Is the patient under a physician's care now?	☐	☐
4.	Any drugs or medication now being taken:	☐	☐
	Give reasons: _____		
5.	Any allergies or drug sensitivity:	☐	☐
	List: _____		
6.	Have tonsils and adenoids been removed?	☐	☐
	If so at what age? _____		
7.	Is there a history in your family of irregular teeth?	☐	☐
	Protruding teeth?	☐	☐
	Congenitally missing teeth?	☐	☐
8.	Has any other member of your family had orthodontic treatment?	☐	☐
9.	Has there been any severe injuries involving the teeth?	☐	☐
	Jaws?	☐	☐
10.	Does the patient have any thumb/finger sucking habits at present?	☐	☐
	In the past?	☐	☐
11.	Is the patient a mouth breather while awake?	☐	☐
	While asleep?	☐	☐
12.	Have any teeth been extracted due to decay?	☐	☐
	To make room for permanent teeth?	☐	☐
13.	Is there a history of lip biting?	☐	☐
	Tooth grinding or clenching?	☐	☐
	Difficulty in chewing?	☐	☐
	Pain on ear region?	☐	☐
14.	Does the patient have any speech problems?	☐	☐
15.	Have there been any previous orthodontic consultations or treatments?	☐	☐
16.	Do you visit your dentist regularly?	☐	☐

IKC ORTHODONTICS
Live Well. Bite Right. Smile Always.

Dr. Iris Kivity-Chandler

The Personal Information Protection & Electronic Document Act

The Canadian government now requires that we have your permission to collect your personal dental and medical information. This information will be used to assess your oral needs and advise you of treatment options. It will allow us to maintain communication with you and to communicate with your dentist, physician and other health care providers as well as provide insurance claim forms and treatment estimates. As well, your personal information can be used for teaching, demonstration purposes on an anonymous basis. Your personal information can also be used to process payments and collect unpaid accounts. Your photos may also be used on an anonymous basis for marketing purposes. All this information will be kept private and confidential; it will be accessible to you upon request.

I give permission to Dr. Kivity-Chandler to collect, use and disclose personal information about _____ for the purposes indicated.

Signature: _____

Print Name: _____

Date: _____

Witness Signature: _____

Print Name: _____

Date: _____

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X-Ray Release Authorization

Patient Name: _____
Date of Birth: ____ / ____ / _____ (mm/dd/yyyy)

Facility Information (Releasing Party):

Facility Name: _____

Address: _____

Phone Number: _____

Release To:
Dental/Medical Office: **_Dr. Kivity-Chandler at IKC ORTHODONTICS_____**

Type of X-Rays:
☐ Bitewings ☐ Panoramic ☐ Full Mouth Series ☐ Other: _____

Delivery Method:
Email to: info@IKCortho.com

Authorization:
I authorize the release of these dental images and release the dental office from liability once the records are transferred as directed.

Patient/Parent Signature: _____
Date: ____ / ____ / _____

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