SPHINX ORTHODONTICS
Uptown smile straightening in downtown Edmonton

Patient Biographical Information

First Name: _____ Middle Initial: _____ Last Name: _____
Birthdate: _____ (dd, mm, yy) Gender: _____ Nickname: _____
Address:_____ City: _____ Province:_____ Postal Code: _____
Phone #: _____ Cell Phone #: _____
Email: _____

Parent or Guardian Information

1st Relationship to patient: _____

First Name: _____ Last Name: _____
Address: _____ City: _____Province: _____ Postal Code: _____
Phone #: _____ Cell Phone #:_____
Work #: _____ Email: _____

2nd Relationship to patient: _____

First Name: _____ Last Name: _____
Address: _____ City: _____Province: _____ Postal Code: _____
Phone #: _____ Cell Phone #:_____
Work #: _____ Email: _____

Insurance Information

Name of insurance company or agency: _____
Group/Policy #: _____ Certificate/ID #: _____
Subscriber Name: _____ Subscriber DOB: _____(dd,mm,yy)

Name of insurance company or agency: _____
Group/Policy #: _____ Certificate/ID #: _____
Subscriber Name: _____ Subscriber DOB: _____(dd,mm,yy)

Dental History

Dentist Name: _____
Last dentist visit: _____ Last dental cleaning: _____
Has the patient had an orthodontic consult or treatment before? . . . . . Yes No
If so, when? _____
What is your main orthodontic concern _____
_____

Last Name:_____First:_____(MI):_____

Please write YES or NO to each question. If unsure of a question, please consult with dentist or receptionist.

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain:_____
   _____.
2. Have you been hospitalized in the past two years?_____
3. When was your last visit to a Physician?_____Last complete physical examination?_____
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs including vitamins or naturopathic substances? Please list:

1._____ 2._____3._____
4._____5._____6._____

5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS- Penicillin, Keflex, Dalacin, Silfa, or other antibiotics, ASPIRIN, VALIUM, CODEINE, NARCOTICS, LOCAL ANAESTHETIC (freezing), any other medicine:_____
6. Have you ever been advised against taking any specific type of medication?_____
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions?_____
8. Do any of these allergic conditions result in headaches, nausea, swelling, shortness of breath, or chest constriction?_____If so, please explain:_____
9. Have you been advised by you Medical Doctor or Dentist to take antibiotics prior to dental treatment?_____
10. Do you bleed EXCESSIVELY from cut or injury, or bruise easily?_____
11. Do you ankles, feet or hands swell?_____
12. Are you thirsty much of the time or urinate more than 6 times per day?_____
13. Has your weight, appetite or energy level changed dramatically recently?_____
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?____
15. Have you tested HIV positive, or come in contact with the AIDS virus?_____
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?_____
17. Have you ever had any injury or surgery to your face or jaws?_____
18. Have you had any other surgeries?_____
19. Do you smoke or use any other forms of tobacco?_____
20. Are you alcohol and/ or drug dependent?_____and, Have you received treatment?_____
    _____
21. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVERHAD:(please circle)

Anemia	Headaches	Malignant Hypothermia
Angina pectoris	Heart disease or attack	Metal allergy
Arthritis/rheumatism	Heart murmur	Migraines
Artificial heart valve	Heart pacemaker	Mistral valve prolapse
Artificial joints (hip, knee)	Heart rhythm disorder	Organ transplant/medical implant
Blood disorders	Heart surgery	Psychiatric treatment
Bronchitis	Hepatitis A	Radiation treatment/ chemotherapy
Cancer	Hepatitis B	Rheumatic/Scarlet fever
Circulation problems	Hepatitis C	Sickle cell disease
Congenital heart lesions	HIV	Sinus trouble
Cortisone/steroids	High/Low blood pressure	Stomach/ intestinal problems
Diabetes	Hodgkin disease	Stroke
Emphysema	Hyper (Hypo) Glycemia	Temporal Arthritis
Epilepsy or seizures	Jaundice	Thyroid disease
Fainting or dizzy spell	Kidney disease	Tuberculosis
Glandular disorders	Latex allergy	Ulcers
Glaucoma	Liver disease	Other_____
Head/neck injuries	Lung disease	Other_____

22. Is there a family history of any of the above condition_____
23. WOMEN ONLY: Are you pregnant or suspect you may be?_____
24. Do you currently have, or have you had in the past, any disease, conditions or problems not listed above?_____
25. Is there anything else about you health we should be made aware of?
    _____
    _____

26. Do you wish to speak to the Doctor privately about any problem or medical condition?
_____

For Doctor's Use: Fit for treatment
_____
_____
_____

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Consent for Records

Patient Name: _____

You have the right to be informed about treatment options to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is meant to ensure you are properly informed so that you may give or withhold your consent.

Consent by: _____ For: _____
Who is under the age of 18. I hereby, freely and willingly consent for Sphinx Orthodontics (Dr. Tarek El-Bialy) to perform the following radiographic procedure:

Cone Beam Computed Tomography

Risks – I understand that there are certain inherent and potential risks in the use of radiation, and that in this specific instance such risk have been minimized by the use of highly collimated x-ray beam, the latest technology in x-ray detectors and the use of lead aprons.

Refusal of Procedure - Your decision to undergo this radiographic examination is voluntary. You may refuse to participate or discontinue participation at any time. **Refusal for the procedure may result in lack of information which could result in a less than optimum treatment for your condition.**

Yes, I understand the risks and benefit of having a cone beam computed tomography scan. I give my consent for this procedure.

Patient/Guardian Signature: _____Date: _____