ORTHODONTIST
Dr. Tim Dumore & Team
COMMITTED TO ORTHODONTIC EXCELLENCE

Welcome to our office!

Please take a few minutes to provide us with the following important information.

Today's date: ____________________

Your name: ______________________________

Home address: ______________________________

City: ______________________________

Postal Code: ______________________________

Home Phone: ____________________ Sex M F

Work Phone: ______________________________

Birth date (DD/MON/YR) ______/______/______

Dentist: ______________________________

Last visit: ______________________________

Employer: ______________________________

Occupation: ______________________________

e-mail: ______________________________

Other adults we should know about? NO

Last name ______________________________

First name ______________________________

Relationship to you? ______________________________

Employer ______________________________

Insurance Company ______________________________

Phone (H) ______________ (O) ______________

Who can we thank for sending you to our office?

O Referred by dentist
O Referred by family/friend
O Saw office in area
O Saw advertisement in ____________________
O Directed from Invisalign
O Our Website
O Other ______________________________

Medical Information:

Do you have (or have you had) any of the following? Please indicate with an [x]

[ ] Allergies/sensitivities to medicine
[ ] Stomach problems
[ ] Asthma: uses inhaler ___x/week
[ ] Bleeding disorders / transfusion / anemia
[ ] Heart problems
[ ] Thyroid disorder
[ ] Emotional/ nervous/ psychiatric issues
[ ] Eye problems
[ ] Bone disorder
[ ] Liver problems / hepatitis
[ ] Kidney problems
[ ] Rheumatic fever
[ ] HIV / AIDS
[ ] Smoke Cigarettes/day _________

Describe any other medical issues (medication, illness, surgery) if not listed above.

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Physician's name ______________________________

Last exam ______________________________

How can we help you?

To satisfy your concerns, we need to know more about your reasons for visiting our office today. Please answer the questions on the opposite side to the best of your ability. If you are here specifically for a jaw joint problem, please advise us since we have a specific questionnaire for such situations.

Continued on reverse

1. Are you satisfied with the way the teeth look? YES NO
If NO, tell us how would you change them? (Try to be specific: upper/lower, front/back teeth should be moved up/down, forward/back…) ____

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2. Do you have any concerns about the bite or the way the teeth fit together? YES NO If YES, please try to tell us what the problem is. ____

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3. Do you have any concerns about the facial appearance/profile? YES NO If YES, please tell us if you know what you would like to see changed. (Try to be specific: upper/lower jaw(s) should be moved up/down, forward/back, show less gum when smiling, lips…)

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4. Are you here mainly on the advice of your dentist? YES NO
5. Anything else you would like to discuss? ____

Dental Background

Additional comments?

When was your last check-up/cleaning with the dentist? _________________
How often do you brush? __________/day Floss? __________/week

Have you had a previous orthodontic treatment or consultation? When?	Yes	No
seen a gum specialist, root canal dentist, oral surgeon, or crown/bridge dentist?	Yes	No
have any ROOT CANALS LARGE FILLINGS CROWNS BRIDGES	Yes	No
been told you have gum disease or periodontal disease?	Yes	No
had trouble associated with dental treatment?	Yes	No
ever injured or broken any teeth? When and what happened?	Yes	No
ever injured the head or face? When and what happened?	Yes	No
had any teeth extracted? Why?	Yes	No
Do you have any missing or extra teeth?	Yes	No
have any problem with eating, chewing, or swallowing?	Yes	No
have any dental/facial pain or headaches?	Yes	No
Frequency? _____times/ week / month		
have a jaw joint that makes noises/hurts when opening/closing/chewing?	Yes	No
grind or clench the teeth together?	Yes	No
have problems breathing through the nose?	Yes	No
speech difficulties?	Yes	No
Are you aware of any swellings or growths in the face or mouth?	Yes	No
Do you have negative or resistant feelings about orthodontic treatment?	Yes	No
Has any member of your family had orthodontic treatment?	Yes	No
Is there any other information that we should know?	Yes	No

Thank you for your patience in filling out this information. Your effort will assist us in treating you to the best of our ability .

Patient Signature____ **Date**________________________

For most patients receiving braces, we are able to extend generous payment terms, often 0% financing. To allow us to do this we may perform a credit assessment. I hereby certify that the information given above is correct. I authorize and consent to the receipt, exchange and use of information about me by Dr. Tim Dumore Dental Corp. for purposes set out under "Use of Personal Information" and to the sharing or exchange of reports and information with credit reporting agencies, credit bureaus and/or any other person, corporation, firm or enterprise with whom I have or propose to have a financial relationship. I authorize these parties to give you the information. The Corporation, through its authorizing officer, authorizes and consents to the receipt and exchange of credit and other information and to the sharing or exchange of reports and information with credit reporting bureaus and/or any other person, corporation, firm or enterprise with whom the company has or proposes to have a financial relationship.

Dated this___day of ___________ 20_________ Applicant (please print)____________________ Signature of Applicant_____________________________

Applicant's date of birth____________________ To provide financing options, we require two pieces of identification: Driver's License_______________________
Manitoba Medical________________________ SIN________________________