Sea to Sky Smiles
— ORTHODONTIC CENTRE —

Dr. Dorothy A. Sonya
Certified Specialist in Orthodontics

PATIENT INFORMATION – ADULT

PATIENT NAME: _____

SEX ASSIGNED AT BIRTH: GENDER IDENTITY:

□ MALE □ FEMALE □ MALE □ FEMALE □ NON-BINARY □ SPECIFY _____

PREFERRED PRONOUNS: HE/HIM/HIS SHE/HER/HERS THEY/THEM/THEIRS

BIRTHDATE: (mm/dd/yyyy) _____/_____/_____ AGE: _____

EMAIL: _____ PHONE: _____

ADDRESS: _____

FOR VIRTUAL APPOINTMENTS: □ iPhone (Facetime) – Cell: _____

□ Zoom

DENTISTS NAME: _____ REFERRAL SOURCE: _____

DENTAL INSURANCE: (Is this your policy? If no, please add the policy holders name and birthdate)

□ YES □ NO

POLICY HOLDER NAME: _____ BIRTHDATE: _____

INSURANCE COMPANY	POLICY NUMBER	CERTIFICATE

PLEASE NOTE

- REGULAR VISITS TO YOUR DENTIST MUST CONTINUE DURING YOUR ORTHODONTIC TREATMENT
- SOME APPOINTMENTS WILL INFRINGE UPON SCHOOL OR WORK HOURS

MAIN REASON/CONCERN FOR ORTHODONTIC CONSULTATION: _____

_____

HAVE YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

Rheumatic Fever	□ YES □ NO	Diabetes	□ YES □ NO
Chronic Kidney Problems	□ YES □ NO	Lung Problems	□ YES □ NO
Epilepsy	□ YES □ NO	Prolonged Bleeding	□ YES □ NO
Heart Problems	□ YES □ NO	Liver Problems	□ YES □ NO

DO YOU HAVE ANY ALLERGIES? □ YES □ NO - If yes, to what? _____

DO YOU HAVE ANY CONDITION THAT COULD AFFECT YOUR IMMUNE SYSTEM? □ YES □ NO
(e.g HIV, AIDS, LEUKEMIA) If yes, please describe your condition: _____

Sea to Sky Smiles
— ORTHODONTIC CENTRE —

Dr. Dorothy A. Sonya
Certified Specialist in Orthodontics

DO YOU HAVE ANY MEDICAL CONCERNS? IF YES, PLEASE LIST THEM BELOW: □ YES □ NO

- _____
- _____
- _____

DO YOU TAKE ANY MEDICATION? IF YSE, PLEASE LIST THEM BELOW: □ YES □ NO

- _____
- _____
- _____

WHEN WAS YOUR LAST DENTAL CHECK UP AND CLEANING: _____

DO YOU HAVE ANY OF THE FOLLOWING HABITS:

GRINDING TEETH AT NIGHT	□ YES	□ NO	NAIL BITING	□ YES	□ NO
SNORING	□ YES	□ NO	MOUTH BREATHING	□ YES	□ NO

HAS ANY MEMBER OF THE FAMILY HAD ANY ORTHODONTIC TREATMENT? □ YES □ NO

HAVE YOU HAD ANY PREVIOUS ORTHODONTIC CONSULTATIONS OR TREATMENT? □ YES □ NO

DO YOU PLAY ANY MUSICAL INSTRUMENTS? □ YES □ NO – IF YES, WHAT? _____

DO YOU SMOKE OR CHEW TOBACCO? □ YES □ NO

FOR WOMEN: ARE YOU PREGNANT? □ YES □ NO

I give permission to allow Dr. D. Sonya to report to my dentist or any other dental professional as they deem necessary. I also give permission for any records made in the process of examination, treatment and retention to be used for purposes of research, education or publication in professional journals. – *initials*_____

Signature: _____ Date: _____