TSAI ORTHODONTICS

New Patient Intake Form

Please complete every section (or on the behalf of your child).

PATIENT INFORMATION

FIRST NAME | MIDDLE | LAST NAME

PREFERRED NAME | DATE OF BIRTH (DD/MM/YYYY) | SEX

STREET ADDRESS | CITY

PROVINCE | POSTAL CODE | CELL PHONE

EMAIL | LANGUAGES SPOKEN AT HOME

SCHOOL & GRADE (IF A STUDENT) | REFERRED BY

PRIMARY REASON FOR SEEKING TREATMENT

RESPONSIBLE PARTY

Complete if someone other than the patient is financially responsible for treatment.

FIRST NAME | MIDDLE | LAST NAME

Relationship to patient
(Self / Mother / Father / Grandparent / Guardian / Spouse / Other)

SPOUSE'S NAME (IF MARRIED) | CELL PHONE

STREET ADDRESS | CITY

PROVINCE | POSTAL CODE | HOME PHONE

EMAIL | WORK PHONE

EMPLOYER | OCCUPATION

DENTAL INSURANCE

Skip this section if you have already provided insurance details or have no coverage.

POLICY HOLDER'S NAME

POLICY HOLDER'S DOB

Policy holder's relationship to patient
(Self / Mother / Father / Grandparent / Guardian / Spouse / Other)

POLICY HOLDER'S EMPLOYER

INSURANCE COMPANY

CERTIFICATE / SUBSCRIBER ID

GROUP / POLICY NUMBER

INSURER ADDRESS

CITY

PROVINCE

POSTAL CODE

INSURER PHONE

Do you have dual dental coverage? (coordination of benefits) ☐ Yes ☐ No
If yes, complete the second plan below.

Secondary Plan

POLICY HOLDER'S NAME

POLICY HOLDER'S DOB

Policy holder's relationship to patient
(Self / Mother / Father / Grandparent / Guardian / Spouse / Other)

POLICY HOLDER'S EMPLOYER

INSURANCE COMPANY

CERTIFICATE / SUBSCRIBER ID

GROUP / POLICY NUMBER

INSURER ADDRESS

CITY

PROVINCE

POSTAL CODE

INSURER PHONE

MEDICAL HISTORY

Is the patient in good health? ☐ Yes ☐ No

Treated by a physician in last 2 years? ☐ Yes ☐ No

Currently taking any medications? ☐ Yes ☐ No

Any allergies? ☐ Yes ☐ No

IF TAKING MEDICATIONS, PLEASE LIST

IF ALLERGIC, PLEASE LIST (INCL. LATEX, NICKEL, ANESTHETICS)

Has the patient had any of the following, now or in the past?

Diabetes ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Autism spectrum disorder	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Nervous disorders	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	Sensory disorder	☐ Yes ☐ No
Prolonged bleeding	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No
Brain injury	☐ Yes ☐ No	Heart trouble	☐ Yes ☐ No
Learning disability	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No	Anemia	☐ Yes ☐ No

OTHER MEDICAL CONDITIONS / DETAILS

DENTAL HISTORY

This helps us communicate and plan your care during treatment.

Jaw joint popping?	☐ Yes ☐ No	Clench or grind teeth?	☐ Yes ☐ No
Injury to head / neck / jaw?	☐ Yes ☐ No	Previously treated TMJ?	☐ Yes ☐ No
Noise / pain in jaw or ears?	☐ Yes ☐ No	Mouth breather?	☐ Yes ☐ No
Missing teeth?	☐ Yes ☐ No	Extra teeth?	☐ Yes ☐ No
Uncomfortable bite?	☐ Yes ☐ No	Oral habits (thumb/finger/nail)?	☐ Yes ☐ No
Previous ortho treatment / consult?	☐ Yes ☐ No	History of jaw joint problems?	☐ Yes ☐ No

LAST DENTAL VISIT (DD/MM/YYYY)

DENTIST'S NAME

DENTAL OFFICE NAME

DENTAL OFFICE EMAIL / PHONE

IF ANY DENTAL QUESTION ABOVE WAS 'YES', PLEASE EXPLAIN

CONSENT & AUTHORIZATION

I attest that the information above is true and accurate. I authorize Tsai Orthodontics to bill my dental insurance for treatment where applicable. I acknowledge that my personal health information will be collected, used, and protected in accordance with the practice's privacy policy under British Columbia's Personal Information Protection Act (PIPA) and Canada's PIPEDA. A copy of the privacy policy is available on request.

SIGNATURE OF PATIENT / PARENT / GUARDIAN

RELATIONSHIP TO PATIENT

DATE

PEDIATRIC SLEEP QUESTIONNAIRE (OPTIONAL)

Please complete this questionnaire on behalf of your child. This optional sleep-breathing screening helps us assess your child's airway and sleep.

	Yes	No	Don't Know
While sleeping, does your child...			
Snore more than half the time?	☐	☐	☐
Always snore?	☐	☐	☐
Snore loudly?	☐	☐	☐
Have "heavy" or loud breathing?	☐	☐	☐
Have trouble breathing or struggle to breathe?	☐	☐	☐
Have you ever...			
Seen your child stop breathing during the night?	☐	☐	☐
Does your child...			
Tend to breathe through the mouth during the day?	☐	☐	☐
Have a dry mouth on waking up in the morning?	☐	☐	☐
Occasionally wet the bed?	☐	☐	☐
Wake up feeling un-refreshed in the morning?	☐	☐	☐
Have a problem with sleepiness during the day?	☐	☐	☐
Has a teacher or other supervisor commented that your child appears sleepy during the day?	☐	☐	☐
Is it hard to wake your child up in the morning?	☐	☐	☐
Does your child wake up with headaches in the morning?	☐	☐	☐
Did your child stop growing at a normal rate at any time since birth?	☐	☐	☐
Is your child overweight?	☐	☐	☐
This child often...			
Does not seem to listen when spoken to directly	☐	☐	☐
Has difficulty organizing tasks	☐	☐	☐
Is easily distracted by extraneous stimuli	☐	☐	☐
Fidgets with hands or feet or squirms in seat	☐	☐	☐
Is "on the go" or often acts as if "driven by a motor"	☐	☐	☐
Interrupts or intrudes on others (e.g. butts into conversations or games)	☐	☐	☐