Dr. Brent Douglas **Dr. Negar Salimi**
Specialists in Orthodontics for Children and Adults www.vancouverbraces.com

A B C

ADULT PATIENT INFORMATION

Date:_____

Patient's name: _____
Last First Middle

Residence: _____
Street City Postal Code

Mailing Address: _____
Street City Postal Code

Home phone:_____ Work phone: _____Cell Phone: _____

Birth date: _____ Age:_____ Preferred Pronouns:_____ Sex: **F** or **M**

Emergency Contact:_____ Emergency contact phone:_____

Email Address:_____

Occupation:_____ Business Address:_____Bus.Tel:_____

Whom may we thank for referring you to our office?_____

Do you carry **dental insurance**? **YES** or **NO**

If YES, please fill out next section if you are providing **additional** insurance information that we did not collect when this first appointment was originally booked.

Plan holder name:_____ Plan holder DOB:_____

Insurance Carrier: _____

Plan/Contract #: _____ Member/Certificate/ID #:_____

MEDICAL HISTORY

Physician _____Date of Last Visit _____
Address _____Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have you seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Dental Anxiety	Hepatitis/Liver problems	Nervous Disorders
ADHD	Diabetes	Herpes	Pneumonia
Anemia	Dizziness	High Blood Pressure	Prolonged Bleeding
Arthritis	Epilepsy	HIV / Aids	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	Kidney problems	Rheumatic Fever
Autism	Heart Problems	Nervous Disorders	Tuberculosis
Bone Disorders	Heart Murmur	Kidney problems	Tumor or Cancer
Congenital Heart Defect			

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____ →

Dr. Brent Douglas **Dr. Negar Salimi**
Specialists in Orthodontics for Children and Adults www.vancouverbraces.com

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____

STOP-BANG Sleep Apnea Questionaire

STOP

Yes No S – Snoring: Do you SNORE (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night?
Yes No T – TIRED: Do you often feel TIRED fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone?)
Yes No O – Observed: Has anyone OBSERVED you stop breathing or choking/gasping during your sleep?
Yes No P – Pressure: Do you have or are being treated for High Blood Pressure?

BANG

Yes No B- BODY MASS INDEX: Body Mass Index more than 35kg/m^2?
Yes No A- Age: Age older than 50?
Yes No N- Neck: Neck size larger? (Measured around Adams Apple)
For male, is your shirt collar 17inches/ 43cm or larger?
For female, is your shirt collar 16 inches/ 41 cm or larger?
Male Female G- Gender

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Douglas to perform a complete orthodontic evaluation.

Signature: _____ Date: _____