Patient Information Sheet

CRICHIGNO ORTHODONTICS

Dr. N. Crichigno, DDS, FRCD (C)
Specialist in Orthodontics & Dentofacial

Nickname: _____ Email Address: _____

Patients Address: _____ Telephone: _____

Birthdate: _____ Age: _____ Sex: _____ Cell : _____

School/Employer: _____ Grade/Position: _____

Interest/Sports _____

Primary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____ Cell #: _____

Responsible Party: _____ Home Phone #: _____

Address: _____ S.I.N # _____

Employer/Address: _____ Employer Phone #: _____

Secondary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____ Cell #: _____

Responsible Party: _____ Home Phone #: _____

Address: _____ S.I.N. # _____

Employer/Address: _____ Employer Phone #: _____

How Did You Hear About Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other _____

Whom May We Thank For Referring You To Us? _____ Present Dentist: _____

Reason For Consultation: _____

Please Circle Yes or No for which the patient has a history:

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	Tooth Grinding	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tuberculosis	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Venereal Disease	Y N
Arthritis	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N		
Aspirin	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N		
Asthma	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N		
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca	Y N		
Bone Disorders	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Painful chewing	Y N	Speech problems	Y N		
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	TMJ problems	Y N		

Any disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Are you allergic to any medications? _____ Thumb/Tongue Habit? _____

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____

Has an orthodontist been consulted previously? _____ Have you had previous orthodontic treatment? _____

Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____

Any other questions? _____

Names and Ages of Brothers & Sisters: _____

I hereby authorize Dr. N. Crichigno and his professional staff to perform an orthodontic evaluation and consent to the taking of x-rays, photographs and other records (if necessary) to determine appropriate orthodontic treatment on above-named patient. The panoramic x-ray is required to properly diagnose your case. There is no charge for this x-ray, although if you request a copy there is a $75.00 processing fee. _____ (Initial)

Signature: _____ Relationship To Patient: Self Date: _____