RIX ORTHODONTICS
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Patient information and medical history

Please complete this form with your information and history.
Please check **only** those that apply.

Name: _____ Mr Mrs Miss Ms Dr

Date of Birth: _____ Age: _____ Gender: ___ Male ___ Female

Alberta Health Care Number: _____

Address: _____ City: _____ Postal Code: _____

Phone #: cell _____ home _____

Email: _____

Family dentist: _____ Referred by: _____

Physician: _____

Name(s) of other family members being treated at our office: _____

MEDICAL HISTORY:

Check any of the following health concerns, past or present

□ ADD/ADHD	□ Bleeding Disorder	□ Heart condition/stroke	□ Rheumatic Fever
□ AIDS/HIV	□ Cancer Treatment	□ Hepatitis/Jaundice	□ Seizures/Epilepsy
□ Anxiety Disorder	□ COVID-19	□ Kidney Disease	□ Sleep Apnea
□ Arthritis	□ Depression	□ Liver Disease	□ Thyroid
□ Asthma	□ Diabetes	□ Mitral valve prolapse	□ Tuberculosis

□ Other_____

_____ I am in good health.
_____ I am under a physician's care. Please explain: _____
_____ I am on medications. Please specify: _____
_____
_____ I have been required to take antibiotics prior to receiving dental treatment.
Please specify: _____

I have or have had:

_____ frequent respiratory infections
_____ frequent ear infections
_____ tubes in the ears
_____ enlarged tonsils or adenoids
_____ tonsils or adenoids removed. If so, when? _____
_____ allergies. Please specify: _____
_____ digestive problems. Please specify: _____

DENTAL HISTORY:

□ Jaw Discomfort □ Tooth Grinding □ Jaw Clicking
□ Tooth Clenching □ Jaw Locking □ Frequent Headaches

_____ I have had injuries/trauma to the face, mouth, or teeth.
Please specify: _____
_____ I am missing or have extra primary (baby) and/or permanent (adult) teeth?
Please specify: _____
_____ I have had primary (baby) and/or permanent (adult) teeth extracted by a dentist.
Please specify: _____

PREGNANCY/BIRTH HISTORY:

My birth was:
□ Premature □ Full term □ C-Section

Please specify any complications with the pregnancy or your birth:
_____
_____
_____

DEVELOPMENT:

_____ I was breast fed. For how long? _____
Please specify any difficulties with breast feeding: _____
_____ I was bottle fed. For how long? _____
_____ I used a pacifier/soother. For how long? _____
_____ I used a sippy cup.
At what age did you start eating soft food? _____ hard food? _____
_____ I am a slow eater.
_____ I am a fast eater.
_____ I am a noisy eater.
_____ I chew with an open mouth.
_____ I tear food into tiny pieces.
_____ I need to drink constantly when eating solid food.
_____ I have difficulty with certain food textures. Please specify: _____
_____ I eat one food at a time.
_____ I do not let different foods touch each other.
_____ I have trouble licking ice cream cones.
_____ I have trouble swallowing in general. Please specify: _____
_____ I have trouble swallowing pills. Please specify: _____
_____ I have jaw joint or facial pain when eating certain foods.
Please specify: _____

BREATHING:

_____ I have trouble breathing through the nose.
_____ I have been assessed by an ENT specialist.
Please specify: _____
_____ I have a pet cat and/or dog.
_____ I breathe through my mouth during the day.
_____ I breathe through my mouth during the night.
_____ I drool while sleeping.
_____ My nose is often "stuffy".
_____ My mouth is often open when watching TV, reading, or using electronic devices.
_____ My lips are usually closed.
_____ My lips are usually apart.
_____ My lips are usually dry or chapped.
_____ I chronically lick my lips.

SPEECH:

_____ I have problems with speech or creating certain sounds. Please specify: _____
_____ I have had speech therapy. Please specify: _____

HABITS:

_____ I sucked my thumb or finger(s). Until what age?_____
_____ I sucked on a blanket. Until what age?_____
_____ I bite/bit my nails. Until what age?_____
_____ I am/was a lip biter. Until what age?_____
_____ I am/was a lip sucker. Until what age? _____
_____ I am a gum chewer.
_____ I have a habit of chewing on pencils/pens.
_____ I have/had some other sucking/biting habit. Please specify: _____
_____ I play a musical instrument. Please specify: _____

SUPPLEMENTAL QUESTIONS:

What is/are the reason(s) for seeking orthodontic treatment?
Please specify: _____
_____ I have had previous orthodontic evaluations.
_____ I have had previous orthodontic treatment.
Please specify: _____
_____ Is there any dental work to be done at your family dentist?
Please specify: _____
When was your last dental checkup? _____

SIGNATURE: _____ **DATE:** _____

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ADULT SLEEP QUESTIONNAIRE

PATIENT NAME _____ DATE _____

Please complete this form as accurately as you can. Orthodontic treatment can have a significant effect on sleep and breathing disorders which can subsequently have a significant effect on your overall health. We will work with you to manage any sleep and/or breathing disorders present.

Please check all of the following items that apply to you:

___ I occasionally snore
___ I frequently snore
___ I have been told that I sometimes stop breathing during sleep
___ I have heavy/loud breathing during sleep
___ I have trouble falling asleep
___ I wake up frequently during sleep
___ I have a restless sleep
___ I frequently breathe through my mouth during sleep
___ I frequently breathe through my mouth during the day
___ I grind my teeth during sleep
___ I experience excess daytime sleepiness
___ I sometimes fall asleep while driving
___ I frequently fall asleep while a passenger in a car
___ I frequently awake with a headache
___ I frequently awake unrefreshed
___ I frequently awake with a dry mouth
___ I frequently awake with nasal congestion
___ I frequently awake with chest pain
___ I frequently awake choking or gasping
___ I frequently awake with excessive sweating
___ I sleep on my front
___ I sleep on my back
___ I have recently gained weight
___ I have recently experienced increased irritability
___ I have recently experienced depression
___ I have recently experienced a deteriorating memory
___ I have high blood pressure
___ I am a smoker
___ I drink alcohol

I routinely get ___ hours sleep per night

PATIENT'S SIGNATURE: _____

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THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 =	No chance of dozing
1 =	Slight chance of dozing
2 =	Moderate chance of dozing
3 =	High chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Rix Orthodontics

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patient's personal information and to utilize all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances described in this form, we also collect, use, and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, cell phone numbers, and e-mail addresses (collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- Financial information may be collected in order to make arrangements for the payment of dental services.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement for payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Patient's Medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patient's Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

We collect Patient's Diagnostic Records (photographs, radiographs (x-rays), and study models) for the purpose of formulating a complete diagnosis. Patient's Diagnostic Records:

- May be used for educational and training purposes as reference material in an educational setting with other dental or medical professionals.
- All personal information (ie. last names) relating the diagnostic records to a specific patient will be removed.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my and/or my child's personal information as set out above.

*Print name of child (if applicable)*_____

_____	_____	_____
Date	Print Name (of Parent and/or Guardian)	Signature

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PATIENT INSURANCE INFORMATION

PATIENT NAME _____ DATE _____

SELF _____

DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY _____

GROUP/POLICY NUMBER _____

ID/CERTIFICATE NUMBER _____

SPOUSE _____

DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY _____

GROUP/POLICY NUMBER _____

ID/CERTIFICATE NUMBER _____

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