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one person, one face, one smile ...

CONSULTATION QUESTIONNAIRE

Patient (Please Print)

Date _____
 Name _____ Address _____ Unit # _____
First Last Initial
 City _____ Postal Code _____ Home Tel: _____ Cell: _____
 Age _____ Birthdate _____ E-mail _____ Sex Male Female
M D Y
 Dentist _____ Dentist Tel: _____ Physician _____

Responsible Party (financial)

Name _____ Birthdate _____ Relationship (to patient) _____
M D Y
 Mailing Address _____ Unit # _____
 Employer _____ Business # _____

Responsible Party (financial, if different from above)

Name _____ Birthdate _____ Relationship (to patient) _____
M D Y
 Mailing Address _____ Unit # _____
 Employer _____ Business # _____

Whom may we thank for referring you to our office?

_____ Dentist _____ Specialist Name _____
 _____ Patient _____ Other Name _____

In order to provide the best possible care for our patients, we would appreciate your accurate completion of the following questionnaire.

Yes	No	Unsure	Medical History
_____	_____	_____	Is the patient in good general health? When was the last medical check-up or visit to a physician? _____
_____	_____	_____	What was the reason for this medical visit? _____
_____	_____	_____	Has there been a change in general health in the past year?
_____	_____	_____	Is there currently treatment ongoing for any medical condition or has treatment been provided within the last year? Please provide reason _____
_____	_____	_____	Is there a history of having been hospitalized for any serious conditions or operations? Please specify _____
_____	_____	_____	Is there currently a need for medications or non-prescription drugs of any kind? If yes, please specify _____
_____	_____	_____	Is there a history of any allergies (i.e. metals, environmental, etc.)
_____	_____	_____	Has there ever been a history of peculiar or adverse reactions to any medications or injections? (i.e. penicillin, aspirin, dental anaesthetics "dental freezing")
_____	_____	_____	Is there a tendency to breathe through the mouth?
_____	_____	_____	Have the tonsils and/or the adenoids ever been removed?
_____	_____	_____	Is there a history of heart or blood pressure problems?
_____	_____	_____	Is there a history of prosthetic cardiac valve, previous infective endocarditis, congenital heart disease (CHD), cardiac transplantation or cardiac valvulopathy?
_____	_____	_____	Has there ever been a history of rheumatic fever?
_____	_____	_____	Has there ever been a history of jaundice, hepatitis or liver disease or knowledge of contact with a person with any of these conditions?
_____	_____	_____	Has the patient ever been advised not to give blood?
_____	_____	_____	Is there a history of conditions that could affect the immune system? (i.e. AIDS, HIV Positive, leukemia, etc.)

Yes	No	Unsure	Medical History (continued)
_____	_____	_____	Is there a tendency to bruise easily or to bleed for a prolonged period of time after being cut?
_____	_____	_____	Is there a history if any of the following? Please tick only those that apply:
			_____ chest pain _____ heart attack _____ stroke _____ prosthetic joint _____ bronchitis
			_____ emphysema _____ asthma _____ tuberculosis _____ epilepsy _____ stomach ulcers
			_____ drug/alcohol dependency _____ arthritis _____ diabetes _____ kidney disease
_____	_____	_____	Does the patient currently smoke or chew tobacco?
_____	_____	_____	For women only – are you pregnant? And if so, what is the expected delivery date? _____

Yes	No	Unsure	Dental History
_____	_____	_____	When was the last dental visit? _____
_____	_____	_____	When were the last dental x-rays taken? _____
_____	_____	_____	Does the patient regularly brush his/her teeth?
_____	_____	_____	Does the patient regularly floss his/her teeth?
_____	_____	_____	Has the patient been seeing a dentist regularly?
_____	_____	_____	Do any of the teeth ache?
_____	_____	_____	Has the patient ever been advised to take antibiotics before dental appointments?
_____	_____	_____	Do the patient's gums bleed when he/she brushes?
_____	_____	_____	Does the patient have any pain when chewing?
_____	_____	_____	Has the patient had implant surgery or jaw joint surgery?
			If yes, please indicate the surgeon's name and date of surgery: _____

_____	_____	_____	Is the patient being followed up by any other dental specialist?
			If yes, please indicate the speacilist's name and speacialty: _____

Please list anything else not mentioned above, regarding the patient's past dental history.

Yes	No	Unsure	Orthodontic History
_____	_____	_____	Is there a history in your family of irregular teeth?
_____	_____	_____	Is there a history in your family of congenitally missing teeth?
_____	_____	_____	Has any other family member had orthodontic treatment?
_____	_____	_____	Is the orthodontic problem obvious to the patient?
_____	_____	_____	Is the patient satisfied with the appearance of the teeth?
_____	_____	_____	Has there been a finger or thumb sucking habit – ongoing/in the past?
_____	_____	_____	Has the patient had any accidents involving the teeth/jaws/nose?
_____	_____	_____	Does the patient suffer from frequent headaches/earaches?
_____	_____	_____	Has the patient had any teeth extracted by the dentist?
_____	_____	_____	Has there been any previous orthodontic treatment?
_____	_____	_____	Have there been any previous orthodontic consultations?

As part of Canada's PIPEDA (Personal Information Protection and Electronic Documents Act) our privacy protocols comply with National and Provincial privacy legislation, the standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law. Privacy of your personal information is an important part of our office as we provide you with quality orthodontic care. We are committed to collecting, using and disclosing your personal information responsibly.

Permission Granted _____
(PARENT/GUARDIAN SIGNATURE)

To the best of my knowledge,
the above information is correct: _____
(SIGNATURE) (DATE)

Reviewed by treating orthodontist: _____
(SIGNATURE) (DATE)

INFORMATION TO OUR PATIENTS

At VILLAGE ORTHOdontics, Murrell Health Services Inc. (Murrell Health), Oak Health Services Inc. (Oak Health), Murrell Technical Services Inc. (Murrell Technical) and Oak Technical Services Inc. (Oak Technical) each independently provide orthodontic hygiene and technical services in a cost sharing arrangement with our Orthodontic Professionals. Murrell Health, Oak Health, Murrell Technical and Oak Technical are each independent corporations owned and operated, respectively, by one of our Orthodontic Professionals and/or members of his family and are under the clinical supervision of our Orthodontic Professionals.