PATIENT CARE SUMMARY

DOUGLAS L. HABERSTOCK, D.D.S., M.D.S.

PATIENT NAME (Last, First, Middle)	AGE	BIRTHDATE
NAME OF PARENT OR SPOUSE		PATIENT MARITAL STATUS
HOME ADDRESS (No. and Street, City, Province)	POSTAL CODE	HOME TELEPHONE NUMBER
EMPLOYED BY	BUSINESS TELEPHONE	EMAIL
METHOD OF PAYMENT PREFERRED ☐ Cheque/Cash ☐ Debit Card ☐ Credit Card	NAME OF SCHOOL	
IF INSURANCE: NAME OF INSURED	INSURANCE COMPANY	
ADDITIONAL INSURANCE COVERAGE		
FAMILY DENTIST	FAMILY PHYSICIAN	REFERRED BY

MEDICAL HISTORY SUMMARY (If item answered with a YES, give details below)

1. Has patient been seriously ill during the last ten years? YES ☐ NO ☐	6. Does the patient or anyone in the family have any of the following:		
2. Is the patient under a physician's care? YES ☐ NO ☐	a. Rheumatic Fever YES ☐ NO ☐	f. Hemophilia YES ☐ NO ☐	
3. Is the patient receiving any medication? YES ☐ NO ☐	b. Diabetes YES ☐ NO ☐	g. Kidney, heart, lung or liver problems YES ☐ NO ☐	
4. Does the patient have any allergies? If yes, please list allergies. YES ☐ NO ☐	c. Epilepsy YES ☐ NO ☐	h. Hepatitis YES ☐ NO ☐	
	d. Cerebral Palsy YES ☐ NO ☐		
5. Date of last medical examination?	e. Tuberculosis YES ☐ NO ☐	i. Syphilis, AIDS or Gonorrhea YES ☐ NO ☐	

Details of Present Illness	
Details of Previous Illnesses	

DENTAL HISTORY SUMMARY

1. Has the patient received an injury to their teeth or jaws? YES ☐ NO ☐	8. Has the patient ever had speech therapy? YES ☐ NO ☐
2. Does the patient have any problems with their teeth or gums? YES ☐ NO ☐	9. Does the patient play a musical instrument? YES ☐ NO ☐
3. Is the patient concerned about the appearance of their teeth / face? YES ☐ NO ☐	10. Are you aware that some appointments will infringe on school/work time? YES ☐ NO ☐
4. Has the patient ever been teased about their appearance? YES ☐ NO ☐	11. Does patient suck their thumb? YES ☐ NO ☐
5. Does the patient want their teeth straightened/ appearance altered? YES ☐ NO ☐	12. Does patient bite their nails? YES ☐ NO ☐
6. Has any member of the family had orthodontic treatment? YES ☐ NO ☐	13. Does patient grind their teeth? YES ☐ NO ☐
7. Has patient had previous orthodontic consultation or treatment? YES ☐ NO ☐	14. Does patient breath through their mouth? YES ☐ NO ☐
a. Date of last dental examination?	c. How many times a day does patient brush their teeth?
b. How many times a year has the dentist examined the patient?	d. Who first noticed the need for orthodontic treatment? ☐ Dentist ☐ Patient ☐ Parent ☐ Other _____

GENERAL PHYSICAL DEVELOPMENTS

FEMALE PATIENTS	1. Has patient started her monthly period? ☐ YES ☐ NO If YES, at what age did this begin?
	2. Age at which mother or older sister started monthly period:
	3. Are you pregnant at the present time? ☐ YES ☐ NO
MALE PATIENTS	1. Has his voice changed? ☐ YES ☐ NO If YES, at what age did this begin?
	2. Has he started to shave? ☐ YES ☐ NO If YES, at what age did this begin?
	3. Does he have acne? ☐ YES ☐ NO If YES, at what age did this begin?

PLEASE MAKE ANY OTHER COMMENTS YOU FEEL MAY BE HELPFUL	
SIGNATURE	RELATIONSHIP TO PATIENT