Dr Morse Stonecypher DDS MS INC
Certified Specialist in Orthodontics

MEDICAL/DENTAL/INSURANCE INFORMATION
UNDER 19 YEARS OF AGE

PATIENT INFORMATION

Last Name ____________ First Name ____________ Middle Name ____________
Date of Birth M / D / YEAR Age ____________ Male ☐ Female ☐
Mailing Address ____________
City ____________ Prov. ____________ Postal Code ____________
Home Phone # ____________ Cell Phone # ____________
Siblings ____________
Immediate family members treated by Dr. Clawson ____________
Family Doctor ____________ Dentist ____________

Mother
First Name ____________
Last Name ____________
Mailing Address ____________
City ____________ Prov ____________
Postal Code ____________
Home Phone # ____________
Cell Phone # ____________
Work Phone # ____________
Email Address ____________

Father
First Name ____________
Last Name ____________
Mailing Address ____________
City ____________ Prov ____________
Postal Code ____________
Home Phone # ____________
Cell Phone # ____________
Work Phone # ____________
Email Address ____________

Please √ Yes or No to the following questions:

Under continuous care of a physician? Yes ☐ No ☐ If Yes, please explain:

____

Prior evaluation for orthodontic treatment? Yes ☐ No ☐
Have tonsils &/ or adenoids been removed Yes ☐ No ☐
History of difficulty or pain when opening mouth? Yes ☐ No ☐
Prior treatment for jaw joint problems (TMJ)? Yes ☐ No ☐
Frequent headaches? Yes ☐ No ☐
Missing or extra teeth? Yes ☐ No ☐
Injury to: Teeth? Yes ☐ No ☐ Mouth? Yes ☐ No ☐ Chin? Yes ☐ No ☐
Clenching or grinding teeth? Yes ☐ No ☐
Mouth breathing? Yes ☐ No ☐
Tongue thrusting? Yes ☐ No ☐
Are antibiotics required prior to dental procedures? Yes ☐ No ☐
Allergies to food or medications? Yes ☐ No ☐ if Yes, Please list:
Allergy to metals? ie: nickel Yes ☐ No ☐
Allergy to latex (gloves or balloons)? Yes ☐ No ☐
Have you had a panorex X-ray in the last 12 months? Yes ☐ No ☐
Females only: are you pregnant? Yes ☐ No ☐

CONFIDENTIAL

HISTORY OF SERIOUS ILLNESSES SUCH AS: (PLEASE ✓ IF APPLICABLE)

- ☐ Abnormal blood pressure
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood disorders
- ☐ Bone disorders
- ☐ **None of the above**
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Lung / breathing problems
- ☐ Mental / nervous disorder

Other illnesses, conditions or any birth defects, please specify:

____

____

I understand that the information I have provided is correct and complete to the best of my knowledge and that it will be held in confidence. I understand that it is my responsibility to inform Dr. Clawson of any change in the medical status of this patient.

____________________ Signature

____________________ Date

____

Please print the name of the person who completed this form and the relationship to the patient

INSURANCE INFORMATION

Is there an insurance plan or plans that covers orthodontic treatment? Yes ☐ No ☐
If "Yes", please complete the following:

Primary Insurance Company (e.g. Manulife):____________________
Policy Holder's Name____________________
Policy Holder's Address____________________
Policy Holder's Date of Birth______ M / D / YEAR ______
Employer____________________

Identification # on card:____________________
(could be listed as ID#, certificate # or SIN #)
Group # on card:____________________
(could be listed as group#, policy#, or plan#)

Secondary Insurance Company (e.g. Manulife):____________________
Policy Holder's Name____________________
Policy Holder's Address____________________
Policy Holder's Date of Birth______ M / D / YEAR ______
Employer____________________

Identification # on card:____________________
(could be listed as ID#, certificate # or SIN #)
Group # on card:____________________
(could be listed as group#, policy#, or plan#)

Is there orthodontic coverage through Dept of Indian Affairs? Yes ☐ No ☐
Is there orthodontic coverage through Ministry of Children and Families or any other Provincial Government Ministry or organization? Yes ☐ No ☐

If the answer is YES to either or both of these questions please be prepared to present the patient's government issued "Status Card" or a "Dental Benefit" card to the receptionist.

CONFIDENTIAL