



**Dr. Nadia Nizam** DDS | MCID | FRCD (C)

30 Springborough Blvd SW  
Suite 245  
Calgary, AB  
T3H 0N9

tel: (403) 457-7700  
fax: (403) 457-4300  
email: info@impressionsortho.ca  
web: www.impressionsortho.ca

**Patient Information**

Name:	_____	_____	_____	Age:	_____
	<i>Last</i>	<i>First</i>	<i>Middle Initial</i>		
Nickname:	_____	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	_____ (MM/DD/YYYY)
Address:	_____	_____	_____	_____	_____
	<i>Street</i>	<i>Apt/Suite</i>	<i>City</i>	<i>Province</i>	<i>Postal Code</i>
Phone:	_____	_____	_____		
	<i>Home</i>	<i>Work</i>	<i>Cell</i>		
Email Address:	_____				
General Dentist's Name:	_____		Physician's Name:	_____	
Emergency Contact:	_____	_____	_____	_____	
	<i>Name</i>	<i>Phone</i>	<i>Relationship to Patient</i>		
Who may we thank for referring you to our office?					
<i>If patient is a minor, please fill the information below:</i>					
Mother's Information:	_____	_____	_____		
	<i>Name</i>	<i>Phone</i>	<i>Work/Cell</i>		
Father's Information:	_____	_____	_____		
	<i>Name</i>	<i>Phone</i>	<i>Work/Cell</i>		
Guardian's Information:	_____	_____	_____		
	<i>Name</i>	<i>Phone</i>	<i>Work/Cell</i>		

**Additional Information**

Height (ft):	_____	Weight (lbs):	_____
School Name:	_____	Grade:	_____
Hobbies:	_____	Musical Instrument(s):	_____
Reason(s) for seeking orthodontic consultation?			
Is there anything special about your child that you would like to share with us?			

**Growth Information for patients under 16 years of age**

Father's Height (ft):	_____	Mother's Height (ft):	_____
Patient resembles:	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Neither Parent		
Girl: Has she started menstruation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	_____
Boy: Has his voice changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	_____
Name and ages of patient's brothers and sisters:			

**Financial Information**

Who is responsible for the patient's account?	<input type="checkbox"/> Patient <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other			
	If Other, specify: _____			
Address (if different from above):	_____	_____	_____	_____
	<i>Street</i>	<i>Apt/Suite</i>	<i>City</i>	<i>Province</i> <i>Postal Code</i>
Do you have insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have more than one insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you know what your orthodontic coverage is?	_____			

## Dental History

	No	Yes	If yes, please explain:
Has the patient had any trauma to teeth/head or face?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a history of thumb/finger sucking or mouth habits?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the patient consulted an orthodontist previously?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the patient had any previous orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the patient ever had a bad dental experience?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the patient have any discomfort with their current bite?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the patient have any speech problems?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Please check if patient has or has had any of the following:</b>			
	No	Yes	
History of jaw joint problems (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in the ears
Clenching/grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint soreness/pain
Muscle soreness of head/neck/jaw joint	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint clicking/popping
Difficulty opening mouth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw joint locking (open/closed)

## Medical History

	No	Yes	
Is your child in good health?	<input type="checkbox"/>	<input type="checkbox"/>	If no, explain:
Is your child currently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	List:
Does your child have any allergies (food/medication/latex/penicillin/metal etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	List:
Does your child bruise easily or bleed profusely?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain:
Has your child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain:
Has your child ever taken Bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when/how much/for what?
<b>Did your child has/had any of the following?</b>			
	No	Yes	
AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/flu
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent cold sores
Bone/Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Frequent cough, skin rash, diarrhea
Cancer/tumor	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches
Congenital Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	Growth Disorder
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Liver Problems
Emotional disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
	No	Yes	
	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing
	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems
	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
	<input type="checkbox"/>	<input type="checkbox"/>	Tonsilitis
	<input type="checkbox"/>	<input type="checkbox"/>	Tonsil removed: Age: ____
	<input type="checkbox"/>	<input type="checkbox"/>	Others: _____

## Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my child's health while he/she is under orthodontic treatment.

I am the parent/guardian of \_\_\_\_\_, I do hereby request and authorize the staff/doctor to  
Name of Minor

perform necessary dental services for the child named above but not limited to x-rays, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

## Insurance Assignment and Release

I certify that my dependent is covered by insurance with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. Nadia Nizam all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed.

\_\_\_\_\_  
 Signature of Patient/Parent/Guardian

\_\_\_\_\_  
 Date