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 _____
Name(s) of all immediate family members who have had braces or aligner treatment at Clawson Orthodontics
_____
Family Doctor_____ Dentist _____

☐ Mother ☐ Guardian ☐ Caregiver ☐ Other_____
First Name_____
Last Name_____
Mailing Address_____
City_____ Prov_____
Postal Code_____
Home Phone #_____
Cell Phone #_____
Work Phone #_____
Email Address_____

☐ Father ☐ Guardian ☐ Caregiver ☐ Other_____
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 adult teeth? Yes☐ No☐
Injury to: Teeth? Yes☐ No☐ Mouth? Yes☐ No☐ Chin? Yes☐ No☐
Clenching or grinding teeth? Yes☐ No☐
Thumb or finger sucking habit? 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 panoramic X-ray in the last 12 months? Yes☐ No☐
Approximately when was your last dental check up_____ ; cavities Yes☐ No☐
Females only: are you pregnant? Yes☐ No☐

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

☐ Abnormal blood pressure	☐ Congenital heart defect	☐ HIV
☐ Anemia	☐ Diabetes	☐ Kidney disease
☐ Arthritis	☐ Epilepsy	☐ Liver Disease
☐ Blood disorders	☐ Heart Murmur	☐ Lung / breathing problems
☐ Bone disorders	☐ Hepatitis	☐ Mental / nervous disorder

☐ **None of the above**

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. Stonecypher 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

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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 Indigenous Services Canada? 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.