Dr. Dan Dagasso
ORTHODONTICS

DATE: _____

Dr. Dan Dagasso BSc, DMD, MCID, FRCD(C)
BC Certified Specialist in Orthodontics and Dentofacial Orthopaedics

PATIENT INFORMATION:

PATIENT NAME: _____

PATIENT AGE: _____ BIRTHDATE (M/D/Y): _____ ☐ MALE ☐ FEMALE

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

DENTIST: _____ PHYSICIAN: _____

Who may we thank for referring you?: _____

ACCOUNT INFORMATION (Person responsible for account):

☐ Mrs. ☐ Mr. ☐ Ms. ☐ Dr. _____ EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

DENTAL INSURANCE: We do NOT bill dental insurance companies directly. Payment from the responsible party is required at the time the services provided. We will aid you with preparing your insurance claims so that you may receive reimbursement directly from your insurance company.

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

BIRTHDATE (M/D/Y): _____ EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP: _____

ID/CERTIFICATE: _____ PATIENT DEPENDENT NUMBER: _____

% ORTHO COVERAGE: _____ COVERAGE LIMIT: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

BIRTHDATE (M/D/Y): _____ EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP: _____

ID/CERTIFICATE: _____ PATIENT DEPENDENT NUMBER: _____

% ORTHO COVERAGE: _____ COVERAGE LIMIT: _____

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MEDICAL HISTORY:

Is the patient in good health? ☐ Yes ☐ No Is the patient under a physician's care? ☐ Yes ☐ No

If yes, please briefly describe: _____

Please list any drugs and/or medications being taken: _____ Give reasons: _____

Please list any allergies or drug sensitivities: _____

Does the patient have a history of any of the following? ☐ Diabetes ☐ Heart Murmur ☐ Epilepsy ☐ Thyroid Disease
☐ Bone Disorder ☐ Rheumatic Fever ☐ Hepatitis ☐ Prolonged Bleeding

Does the patient require antibiotic premedication before dental treatment? ☐ Yes ☐ No

Have the tonsils/adenoids been removed? ☐ Yes ☐ No If yes, at what age? _____

DENTAL HISTORY:

Have there ever been any injury to the face, mouth, or teeth? ☐ Yes ☐ No

If yes, please briefly describe: _____

Has the patient ever sucked a thumb or finger? ☐ Yes ☐ No

Does the patient have any speech problems? ☐ Yes ☐ No

Is the patient a mouth breather? ☐ Awake ☐ Sleeping ☐ Yes ☐ No

Has the patient ever been informed of any missing or extra teeth? ☐ Yes ☐ No

Has the patient ever had a previous orthodontic exam? ☐ Yes ☐ No

Do any relatives have a similar tooth or jaw condition as the patient? ☐ Yes ☐ No

If yes, please briefly describe: _____

Does the patient have anxiety or require extra time for appointments? ☐ Yes ☐ No

If yes, please briefly describe: _____

Has any family member been previously treated in this office? ☐ Yes ☐ No Name: _____

When did the patient last have dental care? _____

Briefly state what you would like to achieve with orthodontic treatment: _____

Please list any sports, hobbies, and/or interests: _____

ANY INFORMATION PROVIDED WILL BE HELD IN STRICTEST CONFIDENCE.
PLEASE INFORM THE OFFICE IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE COURSE OF TREATMENT.