PANORAMA ORTHODONTICS

Dr. Wilbur Chow Inc.
BSc, DMD, MSc, FRCD(C), FCDS(BC)
Certified Specialist in Orthodontics
and Dentofacial Orthopedics

101–15137 56th Ave
Surrey BC V3S 9A5
P: 604.575.8018
F: 604.575.8015

PATIENT INFORMATION (please complete in ink)

Name: _____ Gender: M ☐ F ☐ Date of Birth: ____/____/____
Last First Initial YYYY / MM / DD

Address: _____ Home Phone: _____
Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____ Position: _____

Best telephone number to call for appointments (during business hours): _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married

Dental Insurance: Self: Yes ☐ No ☐ Spouse: Yes ☐ No ☐

Patient's Family Dentist: _____ Phone: _____

Patient's Family Physician: _____ Phone: _____

Whom may we thank for referring you to our office: _____

Dental History

What is your primary concern about your teeth and smile? _____

Yes No

☐ ☐ Are you currently experiencing any dental pain? If yes, describe: _____
☐ ☐ Have you had any permanent teeth removed, including wisdom teeth? How many? _____
☐ ☐ Have you ever had any previous orthodontic treatment? If yes, when? _____ Which doctor? _____
☐ ☐ Have you ever injured your teeth or mouth? If yes, describe: _____
☐ ☐ Do you, or have you, experienced soreness, tightness or pain in the muscles around the jaws and face?
☐ ☐ Do you, or have you, experienced pain in your jaw joints? If yes, when?
☐ ☐ Do you, or have you, experienced clicking, popping or grinding in your jaw joints? If yes, when?
☐ ☐ Do you, or have you, experienced difficulty opening or closing their jaws?
☐ ☐ Have your jaws ever been "locked" open or closed?
☐ ☐ Do you clench or grind your teeth?
☐ ☐ Do you find that you breathe predominantly through your mouth, or with your mouth open?

Medical History

Yes No

- ☐ ☐ Are you under a physician's care at present? If yes, reason: _____
- ☐ ☐ Are you being treated for any medical conditions? If yes, describe: _____
- ☐ ☐ Are you currently taking any prescription or non-prescription medications? If yes, describe: _____
- ☐ ☐ Are you allergic to any medications (e.g. penicillin, sulfa drugs, pain relievers, etc)? If yes, describe: _____
- ☐ ☐ Have you ever had any serious illnesses? If yes, describe: _____
- ☐ ☐ Have you ever been hospitalized or undergone any type or surgery?
- ☐ ☐ Have you ever had prolonged bleeding following a tooth extraction or minor injury?
- ☐ ☐ Are there any conditions of disease that run in your family (e.g. diabetes, heart disease, cancer, etc.)?
- ☐ ☐ Do you smoke or use any other tobacco products? If yes, how much? _____
- ☐ ☐ For women, are you pregnant, or suspect that you might be? Anticipated due date: _____

Have you had, or do you have any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic fever	☐	☐	Kidney Disease	☐	☐	Neck Pain
☐	☐	Heart murmur	☐	☐	Thyroid Disease	☐	☐	Nerve or Brain Disease
☐	☐	Heart / Valve Disease	☐	☐	Lung Disease	☐	☐	Seizures / Epilepsy
☐	☐	Heart attack / Stroke	☐	☐	Asthma	☐	☐	Mental Health Problems
☐	☐	Prosthetic Joint / Valve	☐	☐	Tuberculosis (TB)	☐	☐	Autism
☐	☐	High / Low Blood Pressure	☐	☐	Cancer / Radiation Therapy	☐	☐	Arthritis (any type)
☐	☐	Blood Disorder	☐	☐	Diabetes	☐	☐	Bone Disorders
☐	☐	Hemophilia	☐	☐	Stomach Ulcers	☐	☐	Vision or Hearing Problems
☐	☐	HIV / AIDS Infection	☐	☐	Herpes (any type)	☐	☐	Sleep Apnea
☐	☐	Hepatitis A, B or C	☐	☐	Skin disease (e.g. Eczema)	☐	☐	Sinus Problems
☐	☐	Infectious Disease	☐	☐	Persistent Headaches	☐	☐	Allergies
☐	☐	Liver Disease	☐	☐	Migraine	☐	☐	Other

Please list any other significant information about your medical history: _____

_____

_____

Any other information you can give us is definitely appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. *Also, please include any special interests or hobbies*:

_____

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____	_____	_____	_____
Signature	Date	Dr. Wilbur Chow	Date

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PATIENT CONSENT FORM – COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

At the orthodontic practice of Dr. Wilbur Chow Inc., the privacy of your personal information is of utmost importance. We are committed to collecting, using and disclosing your personal information responsibly. Our policies regarding your personal information are open and transparent.

In this office, Dr. Wilbur Chow acts as the Privacy Information Officer. All staff members are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate uses and protection of your information; we are committed to adhering closely to our Privacy Code. Please do not hesitate to discuss and review our policies and Privacy Code with any member of our team.

We limit the collection of personal information to only the relevant and necessary information. Your personal information will be stored, retained and destroyed in compliance with the existing legislation and privacy protection protocols of our regulatory body, the Royal College of Dental Surgeons of British Columbia, and the federal legislation of the Personal Information Protection and Electronic Documents Act (PIPEDA).

Dr. Wilbur Chow Inc. will collect, use and disclose your personal information for the following purposes:

- to accurately assess your overall medical and dental health in order to provide safe, efficient, quality orthodontic and dentofacial orthopedic assessment, diagnosis and treatment
- to establish and maintain communication with you in regards to all aspects of your care, including assessment, diagnosis, treatment, and your financial matters
- to communicate with your team of health care professionals (e.g. general dentists, dental specialists, medical doctors) in order provide the highest level of comprehensive care in a cohesive manner
- to comply with all legal and regulatory requirements of provincial and federal laws
- to comply with all regulations set forth by the Royal College of Dental Surgeons of British Columbia

If you have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing to our office's Privacy Information Officer.

PATIENT CONSENT

I, _____ , have reviewed the above information regarding the collection, use, and disclosure of my personal information. I give consent for Dr. Wilbur Chow Inc. to collect, use, and disclose the personal information as described above, and in accordance with the Privacy Code of their office.

_____	_____
Patient Signature	Witness
_____	_____
Patient Name (PLEASE PRINT)	Date