

ADULT PATIENT PERSONAL INFORMATION

Chart # _____

Consultation date: _____ **Sex:** Female Male
Name: (Dr/Mr/Mrs/Ms/Miss) _____ **Date of Birth: M** _____ **D** _____ **Y** _____
Address: _____ **Home Phone Number:** _____
City: _____ **Province:** _____ **Work Phone Number:** _____
Postal Code: _____ **Cell Phone Number:** _____
Occupation: _____ **E-mail Address:** _____
Marital Status (check one): Single Common Law Married Separated Divorced Widowed
Person(s) responsible for financial obligation: _____ **Relationship:** _____
 _____ **Relationship:** _____

DENTAL HISTORY

Who is your family Dentist? _____ **Date of last dental check-up:** _____
Have you seen an Orthodontist before? _____ **If yes, when ?** _____
Have you ever required antibiotics or other medications prior to dental treatment? Yes No
Indicate any history of (check all that apply):
 Jaw joint problems Grinding and/or clenching of teeth
 Thumb/finger sucking Injury to face or teeth Tongue position/or swallowing problems
 Tonsils/Adenoids removed Speech/articulation problems Mouth breathing more than nose breathing

MEDICAL HISTORY

Family Physician: _____ **Date of last medical check-up:** _____
Are you currently under medical care? _____ **If yes, explain:** _____
Do you have any drug allergies? _____ **If yes, explain:** _____
Indicate any history of (check all that apply):
 Nickel/metal allergy Latex allergy Rheumatic fever
 Epilepsy or seizures Hereditary problems Asthma Headaches
 Hepatitis Heart murmur Heart problems H.I.V. Positive
 Diabetes Anemia Prolonged bleeding Other: _____

Who may we thank for referring you? _____
Reason for today's visit: _____
I authorize Dr. Boutin to do a clinical orthodontic examination and photographic documentation. _____
 (Patient Signature)

**INSURANCE INFORMATION
For Person(s) Financially Responsible**

Insurance Plan 1 (please print)	Insurance Plan 2 (please print)
Employee's Name:	Employee's Name:
Company Name:	Company Name:
Insurance Company:	Insurance Company:
Group/Policy Number:	Group/Policy Number:
Certificate or I.D. Number	Certificate or I.D. Number
Date of Birth (MM/DD/YY):	Date of Birth (MM/DD/YY):
Relationship to Patient:	Relationship to Patient:

PATIENT INFORMATION

DR. CLAUDE BOUTIN ORTHODONTIST

wired  wireless

MEET DR. BOUTIN

- He has been an Orthodontist for over 20 years and loves straightening teeth!
- He and his wife have raised four children and they have a dog, and a cat at home.
- Dr. Boutin, his wife and all four of his children have had braces.
- His favorite book is The Lord of the Rings, his favorite food is Nanaimo Bars and his favorite music artist is Jim Croce.
- He played hockey for 12 years while growing up and likes fishing, snorkeling, going to the movies, and driving sports cars. He also golfs, but only when friends and family force him to!
- He loves things that fly – he flew radio control aircraft for years and got his pilot's license in 2009 to fly real full-size helicopters (fulfilling a life-long dream!)

NOW TELL HIM ABOUT YOU ...

MY NAME IS:

OCCUPATION:

IF I WAS NOT IN MY CURRENT OCCUPATION I THINK I WOULD BE A:

OUTSIDE OF WORK, I ENJOY SPENDING MY TIME DOING:

FAVORITE RESTAURANT:

FAVORITE TYPE OF MUSIC:

FAVORITE BOOK(S):

FAVORITE MOVIE:

FAMILY/ PETS AT HOME:

MY FAVORITE GUILTY PLEASURE IS: