PATIENT'S DENTAL & MEDICAL HISTORY

As an Orthodontic Specialist we do not check for any cavities or do cleanings. Please return to your family dentist every 3 to 6 months for cleanings and check-ups.

Describe in your own words your orthodontic problem or concern: ______________

____

Dentist's Name: ________________________ last check-up: ________________

Please explain any dental work to be done: ____________________________

____

Have you ever had any orthodontic consultations or treatment? _____ If yes, explain: ____

Does the patient have any history of the following:

- ☐ Joint (TMJ) Problems
- ☐ Missing Teeth
- ☐ Nail Biting
- ☐ Thumb/finger Sucking
- ☐ Gum Disease
- ☐ Trauma to Any Teeth
- ☐ Tongue Thrusting
- ☐ Other

If yes, please describe: ____

____

Physician's name: ________________________ Tel #: ____________________
First Last

Is the patient healthy? __________ If no, please describe medical concerns: ____

____

Are any of the following applicable to the patient:

- ☐ Past Medical Problems
- ☐ Autism
- ☐ Allergies
- ☐ Current Health Concerns
- ☐ Pregnant
- ☐ Medications Required Prior to Dental Visits
- ☐ Medications Currently Taken
- ☐ Other

If yes, please describe:

____

Thank you for referring your friends and family to our office!!

WELCOME!

Drs. Eckler and Black

"Smile Solutions™"

~Orthodontists~

In order to help us accurately diagnose and treat you, **PLEASE FULLY COMPLETE THIS FORM** in clear, legible print.

Dr. Gord Eckler started our practice more than 40 years ago and we have always provided treatment for our patients that we would recommend for our own family. We pride ourselves on our 3-doctor, cooperative approach for all of our patients.

Patients Name: ____

Date of Birth: _________ / ________ / _________ ☐ Male ☐ Female
(month) (day) (year)

Gordon S. Eckler, D.D.S., M.S.
Mark B. Eckler, D.D.S., Dip. Ortho. M.S.D.
Shane M. Black, D.D.S., Dip. Ortho, F.R.C.D.(C.)

55 CITY CENTRE DRIVE, SUITE 505, MISSISSAUGA ON L5B 1M3 (905) 949-6688
150 GREAT LAKES DRIVE, UNIT 135, BRAMPTON ON L6R 2K7 (905) 789-8888

www.smile.com - www.youtube.com/ssortho - twitter.com/smilesolutions

PATIENT INFORMATION

Apt/Suite #: __________ Street: ____

City: _______________ Postal Code: __________ Tel #: __________________

Work #: __________________ Email: ___________________________________

Cell #: __________________ First Language: _____________________________

Have you ever had an orthodontic consultation? ☐ Yes ☐ No
How did you hear about us? Dentist: _____________________________________
Family/Friend: ________________________ Other: ________________________

Hobbies/Interests: ____

How many brothers do you have: ______ Ages: _____________
How many sisters do you have: ______ Ages: _____________

Person(s) responsible for the account: ____________________________________

Relation to patient ____

Employer: ____

Insurance Co: ____

Do you have orthodontic insurance? __________
(Our fees are the same whether or not you have orthodontic insurance but in order to better assist you, we appreciate if you will provide us with your insurance information).

What are the 2 key things that need to happen during treatment for you to feel satisfied with your experience in our office?

1. ____
2. ____

PARENT INFORMATION IF APPLICABLE

Mother's Employer: ____

Insurance Co.: ____

Father's Employer: ____

Insurance Co.: ____

MOTHER'S INFORMATION (if different than patient's):

Name: ____

Apt/Suite #: ________ Street: ____

City: _____________________ Province: ____________ Postal Code: _______

Home #: ______________ Work #: ______________ Cell #: _______________

email: ________________________________ First Language: ______________

FATHER'S INFORMATION (if different than patient's/Mother's):

Name: ____

Apt/Suite #: ________ Street: ____

City: _____________________ Province: ____________ Postal Code: _______

Home #: ______________ Work #: ______________ Cell #: _______________

email: ________________________________ First Language: ______________