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

School: ____________________ Grade: ____________________

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

Best Cell Phone #: ____________________ Best Email Address: ____________________

PARENT INFORMATION

Mother's Name: ____________________ Dental Insurance: ☐ Yes ☐ No
Last First Initial

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

Home Address: ____________________ Home Phone: ____________________
Street City Postal Code

Employer: ____________________ Occupation: ____________________ Position: ____________________

Work Phone: ____________________ Cell Phone: ____________________ Email Address ____________________

Father's Name: ____________________ Dental Insurance: ☐ Yes ☐ No
Last First Initial

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

Home Address: ____________________ Home Phone: ____________________
Street City Postal Code

Employer: ____________________ Occupation: ____________________ Position: ____________________

Work Phone: ____________________ Cell Phone: ____________________ Email Address ____________________

Patient's Family Dentist: ____________________ Phone: ____________________

Patient's Family Physician: ____________________ Phone: ____________________

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

Medical History

Yes No
- ☐ ☐ Is your child under a physician's care at present? If yes, reason: ____
- ☐ ☐ Is your child being treated for any medical conditions? If yes, describe: ____
- ☐ ☐ Is your child currently taking any prescription or non-prescription medications? If yes, describe: ____
- ☐ ☐ Is your child allergic to any medications (e.g. penicillin, sulfa drugs, pain relievers, etc)? If yes, describe: ____
- ☐ ☐ Has your child ever had any serious illnesses? If yes, describe: ____
- ☐ ☐ Has your child ever been hospitalized or undergone any type or surgery?
- ☐ ☐ Has your child 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.)?

Has your child had or does your child have any of the following?

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

Please list any other significant information about the patient's medical history: ____

____

Dental History

What is your primary concern about your child's teeth and smile? ____

What is your child's primary concern about his/her teeth and smile? ____

Yes No
- ☐ ☐ Is your child currently experiencing any dental pain? If yes, describe: ____
- ☐ ☐ Has your child had any primary or permanent teeth removed? How many? ____
- ☐ ☐ Has your child ever had any previous orthodontic treatment? If yes, when? ____ Which doctor? ____
- ☐ ☐ Has your child ever injured his/her teeth or mouth? If yes, describe: ____
- ☐ ☐ Has your child ever complained of soreness, tightness or pain in the jaws or the muscles around the jaws and face?
- ☐ ☐ Has your child ever experienced difficulty opening or closing their jaws?
- ☐ ☐ Has your child's jaws ever been "locked" open or closed?
- ☐ ☐ Does your child have any of the following habits? ☐ Finger Sucking I ☐ Thumb Sucking I ☐ Lip Biting I ☐ Nail Biting
- ☐ ☐ Does your child breathe through their mouth, or with their mouth open?

Growth and Development

Yes No
- ☐ ☐ Has your child reached adolescent growth? ____
- ☐ ☐ Is your child adopted? Does your child know? ☐ Yes ☐ No
- ☐ ☐ Patient's present height ____ Patient's expected height ____ Father's height ____ Mother's height ____
- ☐ ☐ Are there any other children in the family? If yes, names and ages? ____
- ☐ ☐ Has any other members of the family had orthodontic treatment? ____

Any other information you can give us concerning your child 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 the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

____	____	____	____
Signature of Parent / Responsible Adult	**Date**	**Dr. Wilbur Chow**	**Date**

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 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,
(Patient or Parent/Guardian)

and disclosure of the personal information of ____________________ . I give consent for Dr.
(Patient)

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 or Parent/Guardian Signature

_________________________ Witness

_________________________ Patient or Parent/Guardian Name (PLEASE PRINT)

_________________________ Date