PONIKVAR
ORTHODONTICS
Dr. Michael Ponikvar, MSc, MSc, DDS
Board Certified Orthodontist
100 Bell Blvd #210, Belleville | (613) 966-8880 | ponikvarorthodontics@gmail.com
www.ponikvarorthodontics.com

PATIENT INFORMATION FORM

Welcome to our office:
Please assist us by completing the following questionnaire for your examination appointment.

Date of Exam _____

Patients Name _____ Age _____ Birth Date ____/____/____ (Month / Day / Year)
Address _____
Who referred you to our office? _____
Dentist _____ Physician _____
Names of other members of your family treated by our office _____
Insurance Plan Coverage No ☐ Yes ☐ Company _____
Person responsible for account _____ Email _____ Telephone _____
Occupation _____ Employed by _____
Spouse's name _____ Occupation _____
Employed by _____
In case of emergency

History

1. Are you in good health? Yes ☐ No ☐
2. Check if you have had the following or have been treated or are being treated for:

	No	Yes		No	Yes
Diabetes	☐	☐	Tuberculosis	☐	☐
Pneumonia	☐	☐	Anemia	☐	☐
Heart Trouble	☐	☐	Epilepsy	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐
Bone Disorders	☐	☐	Nervous Disorders	☐	☐
Endocrine Problems	☐	☐	Hemophilia	☐	☐
Fainting or Dizziness	☐	☐	Infection of the Heart	☐	☐
Liver Problems	☐	☐	Prosthetic or Artificial Joint	☐	☐
Hepatitis	☐	☐	Cancer	☐	☐
Osteoporosis	☐	☐	Lung Disease	☐	☐
HIV	☐	☐	Arthritis	☐	☐
Sexual Transmitted Infection	☐	☐	Steroid Therapy	☐	☐
Kidney Disorder	☐	☐	Thyroid Disease	☐	☐
Bleeding Disorder	☐	☐	Do you Smoke or Chew	☐	☐
Blood Pressure Problems	☐	☐	Tobacco		
Pregnant or Possibly Pregnant	☐	☐	Cold Sores	☐	☐
Leukemia	☐	☐	Canker Sores	☐	☐
Radiotherapy	☐	☐	Replacement or repair of a	☐	☐
Chemotherapy	☐	☐	heart valve		

Other conditions of which we should be aware _____

3. List any drugs or medication now being taken _____
4. List any allergies or drug sensitivity _____
5. Have your adenoids or tonsils been removed? No ☐ Yes ☐
6. Are you concerned about appearance, chewing, function etc.? No ☐ Yes ☐
7. Have you seen a physician in the last 2 years? If yes, why? No ☐ Yes ☐
8. Have there been any injuries to the face, mouth or teeth? No ☐ Yes ☐
9. Do you have any problems with your speech? No ☐ Yes ☐
10. Do you breathe predominantly through your mouth? No ☐ Yes ☐
11. Do you have frequent headaches? No ☐ Yes ☐
12. Do you have a tendency to frequent colds, sore throats, ear infections? No ☐ Yes ☐
13. Have you had any clicking or discomfort in jaw joints near ears? No ☐ Yes ☐
14. a) Have you been informed of any missing permanent teeth? No ☐ Yes ☐
    b) Have been informed of any extra teeth? No ☐ Yes ☐
15. Have had teeth removed by a dentist? No ☐ Yes ☐
16. Has an orthodontist been consulted previously? No ☐ Yes ☐
17. a) Has there been previous orthodontic treatment? No ☐ Yes ☐
    b) Orthodontist's name _____
18. Has anyone else in the family had an orthodontic problem? No ☐ Yes ☐
19. Do you clench or grind your teeth? No ☐ Yes ☐
20. Have you had any periodontal/gum treatment? No ☐ Yes ☐
21. Do you have sore bleeding gums? No ☐ Yes ☐
22. Do you feel you need orthodontic treatment? No ☐ Yes ☐
23. Are you apprehensive about orthodontic treatment? No ☐ Yes ☐
24. When did you last visit your dentist? _____
25. Were any X-rays taken? No ☐ Yes ☐
26. List sports and interests _____
27. Are you aware most appointments are during school hours? No ☐ Yes ☐
28. Has there ever been a finger/thumb or object sucking habit? No ☐ Yes ☐
29. Reason for orthodontic examination _____