coast
DENTAL
SPECIALISTS

Dr. Asef Karim
Certified Specialist in Orthodontics

NEW PATIENT MEDICAL HISTORY FORM

PERSONAL INFORMATION

Patient's Name:_____ Referred by: _____

Date of Birth: (MM/DD/YYYY) _____ Age: _____

Gender: ○ M ○ F ○ NB

Home Address: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Mobile Phone: _____ Carrier: _____

Email Address: _____

Preferred communication for reminders: ○ Email ○ Phone ○ SMS/Text

Parent or Guardian's Name: _____

Parental Relationship: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Common Law

Parent Occupation: _____

Person Responsible for the Account: _____

Patient's School: _____ Grade: _____

DENTAL INFORMATION

Do you have orthodontic insurance? ○ Yes ○ No

Insurance Name: _____ Percentage: _____ Financial Limit:_____

Group: _____ ID: _____

Patient's Dentist:_____ Last Cleaning Date: _____

Has the patient ever had orthodontic treatment before? ○ Yes ○ No

Have any family members had orthodontic treatment? ○ Yes ○ No

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MEDICAL INFORMATION

Patient's Physician: _____

Do you have a history of or are you being treated for any of the following?

☐ ADD/ADHD	☐ AIDS	☐ Allergies	☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Asthma	☐ Autism Spectrum	☐ Bleeding	☐ Cancer	☐ COVID-19	☐ Diabetes
☐ Down's Syndrome	☐ Emotional Disorder	☐ Emphysema	☐ Epilepsy	☐ Eye Problems	☐ Fainting
☐ Heart	☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Jaundice	☐ Learning/ Behaviourial Disorder
☐ Lung Disease	☐ Nervous Disorder	☐ Sinus Pressure	☐ Sleep Apnea	☐ Stomach Problems	☐ Stroke
☐ Thyroid	☐ Tuberculosis	☐ Others	☐ **None of the above**		

	Y	N
Is general health good?	◉	○
Are you taking any medications?	○	○
Do you have any allergic reactions?	○	○
Do you have a latex allergy?	○	○
Have you ever had an injury, surgery, or x-ray therapy on the head or jaws?	○	○
Any artificial joints, heart valves, pacemaker, or prosthetics?	○	○
WOMEN ONLY: Are you pregnant?	○	○

If you answered YES to any of the above, please comment below:

_____

I authorize Dr. Karim/Coast Dental Specialists team to carry out an examination (including orthodontic photos, digital photographs, digital xrays and 3D scan) on my dependent/myself. I understand that if I would like to have these records transferred there is a fee.
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 a clinical examination.

_____ _____

SIGNATURE (Please sign/type your name) **Date**