Welcome to Glow! We take a human approach that puts you and your family first. Our passion is making people feel confident about their teeth.
Please fill the form completely and accurately.
You can send the completed form to **hello@smilesbyglow.ca** or bring it with you to the first appointment.

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Adult Orthodontic New Patient Form

Patient Information

Patient Name: _____ Preferred Name: _____
Birthdate (MM/DD/YY): _____ Age: _____ Gender: ☐M ☐F
Address: _____ Postal Code: _____
Phone (Home): _____ Phone (Cell): _____
Email: _____ Appointment Reminders By: ☐Email ☐Text
Person Responsible for the Account: _____

Insurance Information

Subscriber: _____
Birthdate (MM/DD/YY): _____
Phone (Cell): _____
Email: _____
Employer: _____
Occupation: _____
Insurance Co: _____
Policy#: _____ ID#: _____

Secondary Plan (If applicable):

Subscriber: _____
Birthdate (MM/DD/YY): _____
Phone (Cell): _____
Email: _____
Employer: _____
Occupation: _____
Insurance Co: _____
Policy#: _____ ID#: _____

Dental History

Family Dentist: _____ Office: _____
Reason for orthodontic consultation: _____
When was the most recent dental check-up? _____
Do you have any pending dental treatments? _____
Have tonsils or adenoids been removed? If so, at what age? _____ ☐Yes ☐No
Have there been any injuries to Teeth Mouth Face Explain: _____
Do you get frequent canker or cold sores? ☐Yes ☐No
Have you ever taken bisphosphonates? (Fosamax, Actonel, Didrocal) ☐Yes ☐No
Are you a mouth breather? ☐Yes ☐No
Do you grind or clench your teeth? ☐Yes ☐No
Do you have difficulty or pain when opening mouth? ☐Yes ☐No
Do you get "locked" jaw? ☐Yes ☐No
Are you aware of noises in the jaw joints? ☐Yes ☐No
Do you have frequent headaches? ☐Yes ☐No
History of habits: ☐Thumb/Finger sucking ☐Tongue thrust ☐Lip biting ☐Nail biting ☐Pen chewing
Have you had any previous orthodontic treatment? ☐Yes ☐No

Medical History

Physician: _____ Physician Tel: _____
Have you ever been treated for any of the following (please indicate):

☐ ADHD ☐ Asthma ☐ Autism ☐ Bleeding/Blood disorder ☐ Bone disorders
☐ Cancer ☐ Congenital birth defect ☐ Diabetes ☐ Epilepsy ☐ Heart disease
☐ HIV/AIDS ☐ Kidney disease ☐ Liver disease/Hepatitis ☐ Lung disease ☐ Rheumatic Fever

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Other details: _____
Current Medication: _____
List any allergies to foods, medications, or latex: _____
Do you require antibiotic premedication before dental work? ☐ Yes ☐ No
For female patients: Are you pregnant? ☐ Yes ☐ No

Referrals--we'd love to say thank you
How did you hear about us? ☐ Dentist ☐ Friend ☐ Google ☐ Social Media Other_____
Referred by: _____

Personal Information Protection Act Consent
I hereby authorize Glow Pediatric Dentistry and Orthodontics to collect, disclose and use information provided by me to communicate with other health professionals, such as dentists and doctors, on my behalf; to communicate with insurance providers on my behalf to obtain estimate and pre-authorization of treatment; and to communicate related services and activities provided by as a newsletter or appointment reminder emails.
Patient Signature _____

Photography and Video Waiver
At Glow, we would like to connect with our patients and families even when you are not in our office. We may take photographs or videos to record the treatment progress or to showcase our patients enjoying themselves in our office or at our events. Examples include pictures of patients on our office wall, on our Facebook or on Instagram. We will not post any photos or videos without your consent.
I allow Glow Pediatric Dentistry and Orthodontics to take photographs and videos and copyright, use and reproduce them in educational, news or promotional material, whether in print, electronic or other media, including the smilesbyglow.ca website. I grant to Glow Pediatric Dentistry and Orthodontics the right to use the name, testimonial, voice, image, and other information of both myself for such purposes. All postings become the sole property of Glow Pediatric Dentistry and Orthodontics. Postings may be displayed, distributed, or used by Glow Pediatric Dentistry and Orthodontics for any purpose whether in whole, part or composite form, electronic, or digital. I agree that no material need be submitted to me for any further approval. I hereby release Glow Pediatric Dentistry and Orthodontics and their successors and assigns, employee, directors and officers and agents from any and all claims arising out of their use of my name, testimonial, voice, image, and biography as agreed to in this document, including without limitation any claims based on the right of publicity or privacy.
Patient Signature _____

Verification of Information
I, the undersigned, declare that all of information provided is true to the best of my knowledge, and I have not knowingly omitted any information. **My signature indicates that I have read all print and understand its content.**

Patient Signature _____ **Date** _____

Witness Name _____ **Witness Signature** _____