

Do you have any of the following? (Please circle yes or no)

Asthma	Yes	No
Hayfever	Yes	No
Bleeding Disorder	Yes	No
Hepatitis	Yes	No
Mononucleosis	Yes	No
Rheumatic Fever	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Heart Problems	Yes	No
Latex Allergy	Yes	No
HIV	Yes	No
Joint Replacement	Yes	No

Are you under a physician's care? Y N

Are you taking any medication? Y N If so, please specify _____ -

Do you have any allergies or drug reactions? Y N If so, please describe:

Any additional comments?

Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law. Only necessary information is collected and we only share information with your consent.

I hereby consent that Dr Berka or her designated staff may release any information pertaining to orthodontic treatment to my dentist or related health professional:

Date _____

Signature: _____