

# WELCOME TO OUR OFFICE

(Please Print)

Patient's name \_\_\_\_\_ Birthdate (M/D/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F  
Surname Given Name  
Home address \_\_\_\_\_ Referred by \_\_\_\_\_  
No. Street  
City \_\_\_\_\_ Employer \_\_\_\_\_  
Province \_\_\_\_\_ Postal Code \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Phone \_\_\_\_\_ Number we can call during business hours: \_\_\_\_\_  
Home Office

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**PERSON FINANCIALLY RESPONSIBLE****HOW DID YOU HEAR ABOUT US?**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
(if different from above)  
City \_\_\_\_\_  
Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Phone \_\_\_\_\_ Work \_\_\_\_\_

- Mailer
  - Flyer
  - Website/Search engine
  - Phone Book
  - Word of Mouth
  - Drove by
  - Local Sponsorships
  - Family or Friend
- If yes who? \_\_\_\_\_

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**Insurance Information**

A dental insurance policy is a contract between you and the insurance company. Our professional services are rendered and charged directly to the patient's account. The person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

Do you have dental insurance? YES NO If yes, please complete the second page. Thank you.

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**Motivation for treatment** Please help us better understand your reasons for seeking an orthodontic consultation by clarifying the following information.

**My reason for seeking a consultation is:**

**If your teeth could be changed, how would you like them to be changed?**

**If your facial appearance could be changed, what would you change?**

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**Medical History****Dental History**

Physician's name \_\_\_\_\_

Dentist's name \_\_\_\_\_

Birth defects? Y N  
Past operations and/or hospitalization? Y N  
Past facial trauma? Y N  
Past or current bleeding disorders? Y N  
HIV/AIDS? Y N  
Hepatitis? Y N  
Past or current allergies? Y N  
Tonsils or adenoids removed? Y N  
Smoker? Howoften? Y N  
Currently taking medications? Y N  
Emotional/psychological problems? Y N  
Other medical problems? Y N

How long have you been going to the above dentist? \_\_\_\_ Yrs  
How often do you go to your dentist?  
\_\_\_\_ Regular Checkups \_\_\_\_ Infrequently \_\_\_\_ Emergencies Only  
When was your last dental appointment? \_\_\_\_\_  
Trauma to your teeth? Y N

	PAST	CURRENT
Thumb or finger sucking?	Y N	Y N
Mouth breathing?	Y N	Y N
Tooth grinding or clenching?	Y N	Y N
Difficulty in chewing?	Y N	Y N
Speech problem?	Y N	Y N
Other jaw problems?	Y N	Y N

Please explain all "yes" answers: \_\_\_\_\_

Please explain all "yes" answers: \_\_\_\_\_

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**Patient signature** \_\_\_\_\_

**Date** \_\_\_\_\_

*Thank you for your patience in filling out this form. It will help us provide you with excellent treatment.*