

WELCOME TO OUR OFFICE

Patient # _____

(Please Print)

| | |
|--|---|
| Patient's name _____ Surname Given Name | Birthdate (M/D/Y) ____/____/____ Sex: M F |
| Home address _____ No. Street | Referred by _____ |
| City _____ Province _____ | School _____ Grade _____ |
| Postal Code _____ Phone _____ | Mother _____ Name Home Ph. Office Ph. |
| Email _____ | Father _____ Name Home Ph. Office Ph. |

PERSON FINANCIALLY RESPONSIBLE

PATIENT'S SIBLINGS

Name _____

Address _____
(if different from above)

City _____

Province _____ Postal Code _____

Phone _____ Work _____

Name _____ Age School _____

Name _____ Age School _____

Name _____ Age School _____

Has anyone else in the family had orthodontic treatment? Y N
Was the treatment for a similar problem? Y N
Was the treatment successful? Y N

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

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?

| Medical History | Dental History |
|---|---|
| Physician's name _____ | Dentist's name _____ |
| Birth defects? Y N | How long have you been going to the above dentist? ____ Yrs |
| Past operations and/or hospitalization? Y N | How often do you go to your dentist? ____ Regular Checkups ____ Infrequently ____ Emergencies Only |
| Past facial trauma? Y N | When was your last dental appointment? _____ |
| Past or current bleeding disorders? Y N | Trauma to your teeth? Y N |
| HIV/AIDS? Y N | |
| Hepatitis? Y N | |
| Past or current allergies? Y N | Thumb or finger sucking? PAST CURRENT Y N Y N |
| Tonsils or adenoids removed? Y N | Mouth breathing? Y N Y N |
| Smoker? Howoften? Y N | Tooth grinding or clenching? Y N Y N |
| Currently taking medications? Y N | Difficulty in chewing? Y N Y N |
| Emotional/psychological problems? Y N | Speech problem? Y N Y N |
| Other medical problems? Y N | Other jaw problems? Y N Y N |
| Please explain all "yes" answers: _____ | Please explain all "yes" answers: _____ |
| Girls: Has menstruation begun? Y N | Has there been a recent growth spurt? Y N |
| Boys: Has voice changed? Y N | |

Parent/Patient signature _____ **Date** _____

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