LindenRidge
ORTHODONTICS
DR. RANA SHENKAROW

WELCOME TO OUR OFFICE

(Please Print)

Patient's name ______________________________
Surname Given Name

Home address ______________________________
No. Street

City __________________ Province ______________

Postal Code _____________ Phone _____________

Email ______________________________________

Birthdate (M/D/Y) _____/_____/_____ Sex: M F

Referred by ______________________________

School ______________________ Grade_________

Mother ______________________________
Name Employer Office Ph.

Father ______________________________
Name Employer Office Ph.

PERSON FINANCIALLY RESPONSIBLE

Name ______________________________________

Address ____________________________________
(if different from above)

City ______________________________________

Province _____________ Postal Code _____________

Phone ________________ Work _________________

PATIENT'S SIBLINGS

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

Physician'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

Please explain all "yes" answers: ________________________
____

Girls: Has menstruation begun?	Y N
Boys: Has voice changed?	Y N

Dental History

Dentist's name ______________________________

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: ________________________
____

Has there been a recent growth spurt? 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.