ADULT ORTHODONTIC CONSULTATION FORM

(PLEASE PRINT)

DATE________________________________

PATIENT'S NAME ____
SURNAME GIVEN NAME INITIAL PREFERED

DATE OF BIRTH _________________________________ AGE _______________ GENDER _______________
MONTH/DAY/YEAR

ADDRESS ____
NO. STREET CITY OR TOWN POSTAL CODE

HOME # ________________________WORK # ________________________ CELL#______________________

EMAIL ADDRESS:____

NAME OF EMPLOYER____

WHO REFERRED YOU TO THIS OFFICE? ____

WHO FIRST NOTICED THE NEED FOR ORTHODONTIC CARE? ______________________________________

REASON FOR ORTHODONTIC CONSULTATION ____

____

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? □ YES □ NO

FOR YOU TO HAVE ORTHODONTIC THERAPY, DO YOU CONSIDER IT:

□ Necessary □ Important □ Desirable □ Indifferent

DO YOU HAVE ANY CONCERNS REGARDING ORTHODONTIC TREATMENT?

____

HAS ANYONE ELSE IN THE FAMILY HAD OR HAVING ORTHODONTIC THERAPY? _______________

IF YES, WHO? ____________________ WHEN? __________________ AND BY WHOM? _________________

HOW HAPPY ARE YOU ABOUT THE TREATMENT RESULTS? ____

____

PERSON FINANCIALLY RESPONSIBLE: □ THE PATIENT **OR**

NAME ____
SURNAME GIVEN NAME

ADDRESS ____
NO. STREET CITY OR TOWN POSTAL CODE

HOME PHONE ___________________________________ BUS. PHONE _________________________________

NAME OF EMPLOYER____

DO YOU HAVE INSURANCE, IF SO NAME OF INSURANCE____

NAME OF POLICY HOLDER ____

MEDICAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

PHYSICIAN'S NAME ____

ADDRESS ____ PHONE ____________________________

CURRENTLY UNDER PHYSICIAN'S CARE? □ NO □ YES ______________________________

CURRENTLY TAKING MEDICATION? □ NO □ YES ______________________________

CURRENTLY UNDER PSYCHOLOGICAL GUIDANCE? □ NO □ YES ______________________________

DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES?

JAUNDICE □ NO □ YES ______________________________

HEPATITIS □ NO □ YES ______________________________

RHEUMATIC FEVER □ NO □ YES ______________________________

OVER→

MEDICAL HISTORY CON'T

OTHER SEVERE ILLNESSES □ NO □ YES ______
REMOVAL OF TONSILS AND/OR ADENOIDS □ NO □ YES ______
OTHER OPERATIONS □ NO □ YES ______

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?
AIDS OR CARRIER OF THE AIDS VIRUS? □ NO □ YES ______
ASTHMA □ NO □ YES ______
ALLERGIES - INCLUDING LATEX OR NICKEL □ NO □ YES ______
BIRTH DEFECTS □ NO □ YES ______
BLOOD DISORDERS □ NO □ YES ______
EPILEPSY □ NO □ YES ______
DIABETES □ NO □ YES ______
HEART AND/OR LUNG CONDITIONS □ NO □ YES ______
FREQUENT □ COLDS □ SORE THROATS □ NO □ YES ______
PREGNANT OR THE POSSIBLITY □ NO □ YES ______
OTHER MEDICAL CONDITIONS NOT LISTED □ NO □ YES ______
MECICATIONS: □ NO □ YES ______

DENTAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

DENTIST'S NAME ______
ADDRESS ______ PHONE ______
HOW LONG HAVE YOU BEEN GOING TO THE ABOVE DENTIST? ______
HOW OFTEN DO YOU GO TO YOUR DENTIST? ______
WHEN WAS YOUR LAST DENTIST APPOINTMENT? ______
HAVE YOU HAD A RECENT ORTHODONTIC EXAMINATION? ______

DO YOU OR DID YOU HAVE ANY OF THE FOLLOWING
INJURY TO HEAD, FACE, MOUTH OR TEETH? □ NO □ YES ______
CLICKING OR DISCOMFORT IN THE JAW? □ NO □ YES ______
GRINDING OR CLENCHING OF TEETH? □ NO □ YES ______
RECURRENT HEADACHES? □ NO □ YES ______
DIFFICULTY IN CHEWING? □ NO □ YES ______
SPEECH PROBLEMS? □ NO □ YES ______
EXTENSIVE DENTAL WORK OR GUM PROBLEMS? □ NO □ YES ______

ARE YOU CONCERNED OR HAVE RESERVATIONS ABOUT
APPREARANCE OF YOUR □ FACE □ LIPS □ GUM □ TEETH? □ NO □ YES ______
WEARING □ BRACES □ NO □ YES ______
CO-OPERATION FOR APPROX. 2 YEARS? □ NO □ YES______
APPOINTMENTS DURING BUSINESS HRS? □ NO □ YES ______

SIGNATURE ______

PLEASE NOTE: IT IS IMPORTANT THAT YOU COMPLETE AND BRING THIS FORM TO YOUR APPOINTMENT OR YOU CAN FAX IT TO (709)-489-1435 OR EMAIL: info@centralortho.ca

IT IS THE POLICY OF THIS OFFICE TO BILL AND RECEIVE FULL PAYMENT FROM OUR PATIENTS. WE REQUIRE THAT YOU MAKE PAYMENTS FROM YOUR INSURANCE COMPANY PAYABLE TO YOU. WE HAVE STANDARD FORMS IN OUR OFFICE FOR YOUR USE.