ORTHODONTIC CONSULTATION FORM

(PLEASE PRINT)

DATE _____

PATIENT'S NAME _____
SURNAME GIVEN NAME INITIAL PREFERED

ADDRESS _____
NO STREET CITY OR TOWN POSTAL CODE

HOME #. _____ CELL #. _____ EMAIL: _____

DATE OF BIRTH _____ PRESENT AGE _____
M/D/Y

SCHOOL _____ GRADE _____ GENDER _____

SPORTS _____ MUSICAL INSTRUMENT _____

WHO REFERRED YOU TO THIS OFFICE? _____

HAS ANYONE ELSE IN THE FAMILY HAD OR HAVING ORTHODONTIC THERAPY? □ YES □ NO

IF YES, WHO? _____ WHEN? _____ AND BY WHOM? _____

HOW HAPPY ARE YOU (AND PARENTS) ABOUT THE TREATMENT RESULTS? _____

_____

DENTAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

DENTIST'S NAME _____

ADDRESS _____

HOW LONG HAVE YOU BEEN GOING TO THE ABOVE DENTIST? _____

HOW OFTEN DO YOU GO TO YOUR DENTIST? _____

WHEN WAS YOUR LAST DENTAL APPOINTMENT? _____

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAMINATION? _____

	CURRENTLY	PAST
INJURY TO THE FACE, MOUTH OR TEETH?	□ NO □ YES _____	□ NO □ YES _____
FINGER, THUMB OR TONGUE SUCKING?	□ NO □ YES _____	□ NO □ YES _____
MOUTH BREATHING WHILE AWAKE?	□ NO □ YES _____	□ NO □ YES _____
GRINDING OR CLENCHING OF TEETH?	□ NO □ YES _____	□ NO □ YES _____
DIFFICULTY IN CHEWING?	□ NO □ YES _____	□ NO □ YES _____
SPEECH PROBLEMS?	□ NO □ YES _____	□ NO □ YES _____
CLICKING OR DISCOMFORT IN THE JAW?	□ NO □ YES _____	□ NO □ YES _____

OTHER ADDITIONAL INFORMATION? _____

MEDICAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

PHYSICIAN'S NAME _____

ADDRESS _____ PHONE _____

CURRENTLY TAKING MEDICATION? □ NO □ YES _____

CURRENTLY UNDER PSYCHOLOGICAL GUIDANCE?□ NO □ YES _____

HAS THE PATIENT HAD THE FOLLOWING ILLNESSESS?

JAUNDICE	□ NO □ YES _____
HEPATITIS	□ NO □ YES _____
RHEUMATIC FEVER	□ NO □ YES _____
OTHER SEVERE ILLNESSES	□ NO □ YES _____
REMOVAL OF TONSILS AND/OR ADENOIDS	□ NO □ YES _____

OVER →

Medical History con't

RECENT OR PERTINENT SURGERY □ NO □ YES _____

DOES THE PATIENT HAVE THE FOLLOWING CONDITIONS?

AIDS OR CARRIER OF 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 _____
ARTHRITIS □ 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 _____
MEDICATIONS □ NO □ YES _____

RESPONSIBLE PARTY INFORMATION

MOTHERS NAME_____
ARE YOU THE LEGAL GUARDIAN □ NO □ YES Birth Date:_____
ADDRESS IF DIFFERENT THAN PATIENT

_____
NO. STREET CITY/TOWN POSTAL CODE
PHONE #'S RES:_____BUS:_____CELL:_____
EMAIL ADDRESS:_____
NAME OF EMPLOYER_____

FATHERS NAME_____
ARE YOU THE LEGAL GUARDIAN □ NO □ YES Birth Date:_____
ADDRESS IF DIFFERENT THAN PATIENT

_____
NO. STREET CITY/TOWN POSTAL CODE
PHONE #'S RES:_____BUS:_____CELL:_____
EMAIL ADDRESS:_____
NAME OF EMPLOYER_____

DO YOU HAVE A DENTAL PLAN COVERING ORTHODONTIC TREATMENT □ NO □ YES
NAME OF INSURANCE COMPANY _____
NAME OF POLICY HOLDER _____

PARENTS/GUARDIAN'S 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.