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#________________

NAME OF EMPLOYER____

EMAIL ADDRESS:____

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____________________________

CO-INSURANCE INFORMATION ____

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 ____________________

DOES THE PATIENT HAVE 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 ____________________

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? ____________________
HAS THE PATIENT 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 OF PATIENT ____________________

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 BLUE CROSS AND STANDARD FORMS IN OUR OFFICE FOR YOUR USE.