

ORTHODONTIC CONSULTATION FORM

(PLEASE PRINT)

DATE _____

PATIENT'S NAME _____

SURNAME GIVEN NAME INITIAL PREFERRED

ADDRESS _____

NO STREET CITY OR TOWN POSTAL CODE

TELEPHONE NO. _____ DATE OF BIRTH _____ PRESENT AGE _____

RESIDENCE MONTH/DAY/YEAR

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 ILLNESSES?

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 POSSIBILITY NO YES _____

OTHER MEDICAL CONDITIONS NOT LISTED 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 _____

CO-INSURANCE INFORMATION _____

PARENTS/GUARDIAN'S SIGNATURE: _____

PLEASE NOTE: IT IS IMPORTANT THAT YOU COMPLETE AND BRING THIS FORM TO YOUR APPOINTMENT.

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.