WELCOME TO OUR OFFICE

(Please Print)

Patient's name _____ Birthdate (M/D/Y) _____/_____/_____ Sex: M F
Surname Given Name

Home address _____ Referred by _____
No. Street

City _____ Employer _____

Province _____ Postal Code _____ E-mail Address _____

Phone _____ Number we can call during business hours: _____
Home Office

PERSON FINANCIALLY RESPONSIBLE

Name _____

Address _____
(if different from above)

City _____

Province _____ Postal Code _____

Phone _____ Work _____

HOW DID YOU HEAR ABOUT US?

- o Mailer
- o Flyer
- o Website/Search engine
- o Phone Book
- o Word of Mouth
- o Drove by
- o Local Sponsorships
- o Family or Friend
  If yes who? _____

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 If yes, please complete the second page. Thank you.

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? How often?	Y N
Currently taking medications?	Y N
Emotional/psychological problems?	Y N
Other medical problems?	Y N

Please explain all "yes" answers: _____
_____

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: _____
_____

Patient signature _____ **Date** _____

Thank you for your patience in filling out this form. It will help us provide you with excellent treatment.