SURRIDEO ORTHODONTICS **ADULT ORTHODONTIC CONSULTATION FORM**

(**PLEASE PRINT**)

Please take a few minutes to provide us with the following important information. Date _____

Patient Name _____
Surname Given Names

Date of Birth _____ _____ _____ Age _____ ☐ Male ☐ Female E-mail _____
Month Day Year

Address _____
Street City or Town Postal Code

Telephone # _____ Cell # _____ Business # _____

Spouse's Name _____ Business # _____
Surname Given Names

Who referred you to this office? ☐ Dentist ☐ Family/Friend ☐ Internet ☐ Yellow Pages.ca ☐ Advertisement ☐ Other_____

Who first noticed the need for Orthodontic care? ☐ Dentist ☐ Patient ☐ Other

Reasons for Orthodontic consultation _____

Do you consider it a high priority for you to have Orthodontic therapy? ☐ Yes ☐ No
Have you had previous Orthodontic therapy? ☐ Yes ☐ No
Were you satisfied with the results? ☐ Yes ☐ No
Has anyone else in your family had or is having Orthodontic therapy? ☐ Yes ☐ No

If yes, who? _____When? _____ and by Whom? _____

Was the treatment for a similar problem? ☐ Yes ☐ No

How happy are you with the treatment results? _____

What do you think that Orthodontic therapy can do for you? _____

Do you consider it: ☐ Necessary ☐ Important ☐ Desirable ☐ Indifferent for you to have Orthodontic therapy?

Are you anticipating a move to another city within the next year? ☐ Yes ☐ No ☐ Possibly

Person financially responsible: ☐ The patient: or

Name _____
Surname Given Name Initial

Address _____
Street City or Town Postal Code

Telephone # _____ Business #_____

Do you have a Dental Plan covering Orthodontic Therapy? ☐ No ☐ Yes

Subscriber_____ DOB _____Name of Ins Co_____ Policy #_____ID# _____

Subscriber_____ DOB _____Name of Ins Co_____ Policy #_____ID# _____

Since it is the policy of this office to bill and receive full payment from our patients, we request that you make payments from your insurance company payable to you.

PLEASE NOTE – IT IS IMPORTANT THAT YOU BRING THESE COMPLETED FORMS TO YOUR APPOINTMENT

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 _____

Have you had the following illnesses/conditions?

Allergies □ No □ Yes _____
Anaemia □ No □ Yes _____
Arthritis □ No □ Yes _____
Asthma □ No □ Yes _____
Birth Defects □ No □ Yes _____
Bleeding Disorders □ No □ Yes _____
Cerebral Palsy □ No □ Yes _____
Diabetes □ No □ Yes _____
Epilepsy/Seizures □ No □ Yes _____
Frequent □ Colds □ Sore throats □ No □ Yes _____
Hearing Problem □ No □ Yes _____
Heart & Lung Conditions □ No □ Yes _____
Hepatitis □ No □ Yes _____
History of joint prostheses in past 2 years □ No □ Yes _____
History of antimicrobial therapy □ No □ Yes _____
HIV/AIDS □ No □ Yes _____
Jaundice □ No □ Yes _____
Kidney Disease □ No □ Yes _____
New Cough or Shortness of Breath □ No □ Yes _____
New onset of diarrhea □ No □ Yes _____
New undiagnosed rash, lesion, or break in skin □ No □ Yes _____
Pregnancy □ No □ Yes _____
Radiation Therapy □ No □ Yes _____
Removal of Tonsils and/or Adenoids □ No □ Yes _____
Rheumatic Fever □ No □ Yes _____
Other Severe Illness Medical Conditions/Operations Not Listed □ No □ Yes _____
Recent exposure to communicable infectious diseases
(Measles, mumps, chicken pox, or TB) □ No □ Yes _____
Family History of prior disease, or symptoms that may be
Indicative of CJD, such as sudden onset of dementia □ No □ Yes _____

DENTAL HISTORY

(PLEASE EXPLAIN ALL "YES" ANSWERS)

Dentist's Name _____ Address _____ Phone # _____
How long have you been going to the above dentist? _____Years
How often do you go to your dentist? □ Regular Check–ups □ infrequently □ only for emergencies □ Never

When was your last dental appointment? _____ Have you had a recent orthodontic examination? _____

Do you or did you have any of the following?

Injury to the head, face, mouth or teeth? □ No □ Yes _____
Clicking or discomfort in the jaw joints in front of the ears? □ No □ Yes _____
Sore jaw muscles □ No □ Yes _____
Tooth grinding or clenching □ No □ Yes _____
Recurrent headaches? □ No □ Yes _____
Difficulty in chewing? □ No □ Yes _____
Speech problem? □ No □ Yes _____
Extensive dental work or gum problems? □ No □ Yes _____

Are you concerned with or have reservations about

Appearance of your □ Face □ Lips □ Gum □ Teeth? □ No □ Yes _____
Wearing Braces? □ No □ Yes _____
Co-operation for approximately two years? □ No □ Yes _____
Some appointments during work/school hours? □ No □ Yes _____
Any other concerns: _____

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Patient's Signature _____

Date _____

SURRIDEO ORTHODONTICS
PERSONAL INFORMATION CONSENT FORM

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home address, work address, home telephone numbers, work telephone numbers, mobile phone numbers, and email addresses. (Collectively referred to as "Contact Information").

Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for orthodontic services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimburse from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further Orthodontic examination or treatment.
- To send patients informational material about our Orthodontic practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of Orthodontic treatment.

Financial Information may be collected in order to make arrangements for the payment of Orthodontic services.

We collect information from our patients about their health history, their family history, physical condition, and are used for the purpose of diagnosing orthodontic conditions and providing Orthodontic treatment.

Patients' Medical Information is disclosed:

- To third party health providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of Orthodontic treatment.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other health care professionals for academic teaching purposes.
- To other dentists and dental specialists if the patients with their consent, has been referred by us to the other dentists and dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our Orthodontic practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists and Orthodontists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of the regulatory activities in public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Date	Print name	Signature