SURRIDEO ORTHODONTICS

CHILD ORTHODONTIC CONSULTATION FORM

(PLEASE PRINT)

Please take a few minutes to provide us with the following important information. Telephone # ____________________ Date ______________
Residence

Patient's Full Name ____
Surname   Given Names

Date of Birth__________ ________ _________ Present Age _____ ☐ Male ☐ Female E-mail ____________________
Month   Day   Year

Address ____
Street   City or Town   Postal Code

School ____________________ Grade _____ Musical Instrument ____________________ Sports ____________

Family Information – *The following information is requested so that we can communicate properly with the people involved with your child's treatment.*

- Parents are ☐ married ☐ separated ☐ divorced ☐ remarried ☐ widowed
- Child lives with ☐ both parents ☐ other ______________________________
- Who should receive routine information about treatment progress? ____________________

No. of children in the family _______ Ages of Brother(s) ____________________ Ages of sister(s) ____________________

Parent/Guardian ______________________________ E-mail Address ______________________________

Address ____
Street   City or Town   Postal Code

Telephone________________________ ________________________ ________________________
Home   Business   Cell

Parent/Guardian ______________________________ E-mail Address ______________________________

Address ____
Street   City or Town   Postal Code

Telephone ________________________ ________________________ ________________________
Home   Business   Cell

Other adults we should know about? ☐ **NO** ☐ **YES Last** Name ____________________ First Name ________________

Relationship to Patient? __________________ Phone ________________________ ________________________
Home   Cell

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 ____

What do you (and your parents) think that orthodontic therapy can do for you? ______________________________

Do you (and your parents) consider it ☐ Necessary ☐ Important ☐ Desirable ☐ Indifferent for you to have orthodontic therapy?

What do you (and parents) consider to be two of the most positive aspects of orthodontics?

1. ____
2. ____

What are your (and your parents) two major concerns regarding orthodontics?

1. ____
2. ____

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 results? ____

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

DENTAL HISTORY (PLEASE EXPLAIN ALL "YES" ANSWERS)

Dentist's Name __________________________ Address ____Phone # _____________________

How long have child been going to the above dentist? ______Years When was your last dental appointment? _________________

How often do you go to your dentist? ☐ Regular Check -ups ☐ infrequently ☐ only for emergencies ☐ Never

Have you had a recent orthodontic examination? ____

Does your child or did your child 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 chewing? ☐ No ☐ Yes ____
Speech problems? ☐ No ☐ Yes ____
Extensive dental work or gum problems? ☐ No ☐ Yes ____

Are you or your child concerned with or have reservations about

Appearance of your ☐ Face ☐ Lips ☐ Gum ☐ Teeth? ☐ No ☐ Yes ____
Wearing Braces? ☐ No ☐ Yes ____
Co-operation with Orthodontic Treatment? ☐ No ☐ Yes ____
Appointments during work/school hours? ☐ No ☐ Yes ____
Any other concerns:____

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 ____

Has your child ever 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 ____
Recent exposure to communicable infectious diseases
(measles, mumps, chicken pox, or TB) ☐ No ☐ Yes ____
Rheumatic Fever ☐ No ☐ Yes ____
Other Severe Illness/Medical Conditions/Operations
Not Listed ☐ No ☐ Yes ____
Family History of prior disease, or symptoms that may be
Indicative of CJD, such as sudden onset of dementia ☐ No ☐ Yes ____

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

Person Financially Responsible:

Name ____
Surname Given Name Initial

Address ____
Street City or Town Postal Code

Telephone ______________________ ________________________ _____________________
Residence Phone Business Phone Cell#

Do you have a dental plan covering orthodontic treatment: ☐ 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.

Parents/Guardian Signature: ____

Date: ____

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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