Ancaster Orthodontics
Consultation Questionnaire

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PATIENT (Please print)

Name _____ Age____ Birthdate (dd/mm/yyyy) ____/____/_____
Res. Address _____ City _____ Postal Code_____
We send courtesy appointment reminders via phone, text or email. Please provide us with your cell number for text reminders.
Home Phone (____) _____ Cell Phone (____) _____Work Phone (____) _____
Email _____ Male ____Female____
Dentist _____ Physician _____
Name of school attending _____
List any sports, hobbies or musical instruments played _____

RESPONSIBLE PARTY

Name (if different from above)_____Relationship (to patient) _____
Address _____ City _____Postal Code _____
Occupation _____ Bus. Phone _____
For children under 18 years of age Patient lives with: Mother ❑ Father ❑ Both ❑
Who is legally permitted to give consent for the patient Mother ❑ Father ❑ Both ❑
Who may we thank for referring you to our office? Dentist ❑ Yellowpages❑ Online❑ Family/friend❑ Name_____

Dental Insurance --- Yes ❑ No ❑ Orthodontic Insurance --- Yes ❑ No❑

MEDICAL HISTORY

Is the Patient in good health .....Yes ❑ No ❑

is there a history of…..

Fainting or Dizziness	❑	Diabetes	❑	Pneumonia	❑
Nervousness or Psychiatric Disorders	❑	Other Endocrine	❑	Asthma	❑
Epilepsy	❑	Bone Disorders	❑	Tuberculosis	❑
Anemia	❑	Heart Trouble	❑	Kidney Involvement	❑
Prolonged Bleeding	❑	Rheumatic Fever	❑	Liver Transplant	❑
Cancer	❑	Other Major illness_____			

List any drugs or medications now being taken. Give reasons.

_____
List any Allergies or Drug sensitivities_____
Does the patient have frequent Colds ❑ Sore Throats ❑ Canker Sores ❑ Ear Infections ❑
Have tonsils and adenoids been removed? What age? _____ Yes ❑ No ❑
Is the patient pregnant or trying to get pregnant? ..... Yes ❑ No ❑

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth?
No/Yes (Explain): _____
Has the patient ever sucked a thumb or finger?
No/Yes (Until what age): _____
Does the patient have speech problems?
No/Yes (Explain): _____
Is the patient a mouthbreather?
No/Yes _____
Have you been informed of any missing or extra teeth?
No/Yes _____

When did the patient last have dental care?
_____
Is the patient apprehensive toward dental visits?
No/Yes _____
Does the patient want orthodontic treatment?
No/Yes _____
Has the patient had previous orthodontic consultations?
No/Yes _____
Reason for orthodontic consultation
_____

Signature of Responsible Party/Patient: _____ **Date:** _____
Signature of Doctor: _____ **Date:** _____
Reviewed by treating Orthodontist