ORTHODONTIC CONSULTATION FORM (PLEASE PRINT)

Date...... PATIENT'S NAME Last Name Given Name Initial ADDRESS No. Street City/Town Postal Code TELEPHONE NO. ********************************** Residence BIRTH DATE Day Month SCHOOL..... GRADE..... SPORTS..... MUSICAL INSTRUMENT..... AGES OF BROTHERS..... AGES OF SISTERS..... WHO REFERRED YOU TO OUR OFFICE..... HAS ANYONE ELSE IN THE FAMILY HAD ORTHODONTIC TREATMENT?YESNO WAS TREATMENT FOR A SIMILAR PROBLEM?YESNO "INFORMATION TO OUR PATIENTS The technical services provided at our orthodontic facility, including the provision of dental hygiene services, x-ray services and laboratory services are provided by Visconti Health Services Inc. This Company is owned and operated by Dr. Visconti and members of her immediate family. All technical health care services provided by Visconti Health Services Inc. are provided under the clinical supervision of Dr. Visconti." PERSON FINANCIALLY RESPONSIBLE: Name..... Address..... Street City/Town Postal Code TELEPHONE NO. Residence Business phone DO YOU HAVE A DENTAL PLAN COVERING ORTHODONTIC TREAMTENT?YesNo NAME OF INSURANCE COMPANY INVOLVED:

IF THERE IS INSURANCE COVERAGE, PLEASE BRING THE NECESSARY FORMS TO THE CONSULTATION APPOINTMENT. SINCE IT IS THE POLICY OF THIS OFFICE TO BILL AND RECEIVE FULL PAYMENT DIRECTLY FROM OUR PATIENTS, WE REQUEST THAT YOU MAKE PAYMENTS FROM YOUR INSURANCE COMPANY PAYABLE TO YOU.

MEDICAL HISTORY

PHYSICIAN'S NAME				
CURRENTLY UNDER A PHYSICIANS CARE?		Yes	1	No
CURRENTLY TAKING MEDICATION?			1	
CURRENTLY UNDER PSYCHOLOGICAL GUIDA			1	
SEVERE ILLNESSES?			1	
OPERATIONS?				
BLEEDING DISORDERS?			1	
ALLERGIES?			1	
BIRTH DEFECTS?				110,550
TONSILS AND/OR ADENOIDS REMOVED?			N	
TONSILS AND/OR ADENOIDS REMOVED!		1 65		NO
PLEASE EXPLAIN ALL "YES" ANSWERS				
DENTAL	HISTOR	Y		
DENTIST'S NAME				rw:
HOW LONG HAVE YOU BEEN GOING TO THE	ABOVE DE	ENTIST?	Y	ears
HOW OFTEN DO YOU GO TO YOUR DENTIST?)	R	egular ch	eck ups
	************	Inf	requently	y
		Or	ıly for Er	nergencies
		Ne	ver	
WHEN WAS YOUR LAST DENTAL APPOINTM	ENT?			
PAST			CURRE	NTLY
THUMB OR FINGER SUCKINGYes	No		Ves	No
MOUTH BREATHING Yes				No
TOOTH GRINDING OR CLENCHINGYes				No
DIFFICULTY IN CHEWINGYes				No
				No
SPEECH PROBLEMYes	NO	*********	res	N0
PLEASE EXPLAIN ALL "YES" ANSWERS				