INITIAL CONSULTATION CARD

Patient ID # _____

NAME _____

Date _____

CLIENT INFO: PLEASE PRINT

Name: _____

First Name Middle Name Last Name

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Month/Day/Year

Client Address: _____ City: _____ Postal Code _____

Phone (home): _____ (work): _____ (cell): _____

Email address: _____

School: _____ Work: _____

Dentist _____ Physician _____

Client lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other:

_____

_____

PARENT OR GUARDIAN: PLEASE PRINT

Mother/Guardian: _____

Address: _____

Phone (home): _____ (work): _____ (cell): _____

Email address: _____

Father/Guardian: _____

Address: _____

Phone (home): _____ (work): _____ (cell): _____

Email address: _____

MEDICAL HISTORY

Present General Health _____

History of Serious Illness _____

Medication @ Present _____

Allergies _____

Breathing Problems _____

Speech Problems _____

Hearing Problems _____

Sight Problems _____

Heart or Circulatory _____

Systemic _____

GUIDELINES FOR YOUR ORTHODONTIC APPOINTMENTS

Consultation Fee of $50.00 is due at the time of the appointment, if you require insurance forms, they will be provided, however we do not submit to the insurance company, that is your responsibility.

Check in at Reception, as soon as you come into the office. (We may recognize your smile and your face, but give us your name just in case).

Be seated until your name is called.

Please be prompt for all appointments. Due to our scheduling procedures, anyone more than 20 minutes late will be rescheduled at our earliest appointment. If you miss your appointment, you will also be rescheduled at our earliest convenience.

Please remember that a high percentage of our patients are of school age and there may not be enough time after school to see every patient. Therefore, scheduled appointments vary between "before, during and after school" time.

If an **Orthodontist-Patient** relationship is to be successful, co-operation is essential.

An **Outstanding Account** will result in delayed treatment, additional fees and or the possibility or early removal of any appliance. Braces will not be removed until account is paid in full.

PRIVACY

As your doctor, my staff and I are bound by law and ethics to safeguard your privacy and the confidentiality of your personal information. This includes:
*collecting only the information that may be necessary for your care
*keeping accurate and up to date records
*safeguarding the medical records in my possession
*sharing information with other health-care providers and organizations on a need to know basis where required for your health care
*disclosing information to third parties only with your express consent, or when necessary for legal reasons and
*retaining/destroying records in accordance with the law.
Your request for care from me implies consent for our collection, use and disclosure of your personal information for purposes related to your care. As noted above, other purposes require your express consent.
You have the right to see your records. You may also obtain copies of your records - please see the receptionist for our fees for this service. Please speak to me if you have any concerns about the accuracy of your records.
If you would like to discuss our privacy policy in more detail, or have specific questions or complaints about how your information is handled, please ask.

Thank you for your cooperation.

Signature: _____ Date: _____
Patient Signature

Signature: _____ Date: _____
Responsible Party Signature