Dr. Lorne S. Kamelchuk*
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www.calgaryorthodontist.com

NW Group Calgary Orthodontics

ADULT PATIENT PERSONAL INFORMATION

Consultation date:
Date of birth:
Name: (Dr/Mr/Mrs/Ms/Miss)
Nickname:
Gender:
Patient's address:
Home phone number:
City:
Province:
Work phone number:
Postal code:
Mobile phone number:
Occupation:
Email address:
Emergency contact:

DENTAL HISTORY

Who is your family Dentist?
Date of last check-up:
Have you seen an Orthodontist before?
If yes, when most recently?
Indicate any history of (check all that apply):

Jaw joint problems
Grinding/clenching of teeth
Thumb/finger sucking
Injury to face or teeth
Tongue and/or swallowing problems
Tonsils removed
Speech/articulation problems
Mouth breathing preferred to nose breathing

MEDICAL HISTORY

Family Physician:
Date of last check-up:
Are you currently under medical care?
If yes, explain:
Do you have any drug allergies?
If yes, explain:

Indicate any history of (check all that apply):

Epilepsy/seizures
Nickel/metal allergy
Latex allergy
Rheumatic fever
Anemia
Sleep Apnea
Hepatitis
Hereditary problems
Asthma
Headaches
Prolonged bleeding
Diabetes
Heart murmur
Heart problems
H.I.V. Positive
Other:

Where did you *first* discover our clinic?
Reason for today's visit:

NO YES

I consent to having Dr. Kamelchuk do a clinical orthodontic examination with diagnostic imaging.

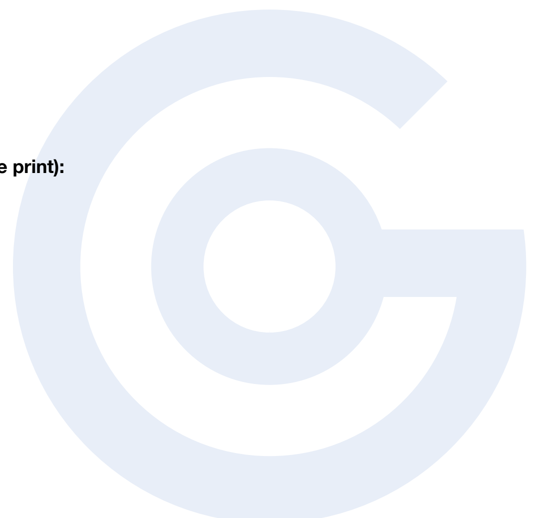
I consent to the discretionary and anonymous use of clinical photos and x-rays for Dr. Kamelchuk's educational/teaching purposes.

I have reviewed Dr. Kamelchuk's privacy policy.

I consent to Dr. Kamelchuk and staff communicating with me for billing and other treatment information purposes via email at the following address:

Chart Number:

Patient signature



INSURANCE INFORMATION

Insurance Plan 1 (please print):

Subscriber's Name:
Date of Birth:
Relationship to Patient:
Insurance Company:
Group / Policy ID #
Certificate / ID #

Insurance Plan 2 (please print):

Subscriber's Name:
Date of Birth:
Relationship to Patient:
Insurance Company:
Group / Policy ID #
Certificate / ID #