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

Group Calgary Orthodontics

To fill out with pen:

Or fill out electronically and sign after printing:

Print Blank Form

Print Complete Form

CHILD PATIENT PERSONAL INFORMATION

Consultation date: MM-DD-YYYY Date of birth: MM-DD-YYYY

Patient's name: _____ Nickname: _____ Gender: _____

Patient's address: _____ Home phone number: _____

City: _____ Province: _____ Postal code: _____ Email: _____

DENTAL HISTORY

Who is your family Dentist? _____ Date of last check-up: MM-DD-YYYY

Have you seen an Orthodontist before? _____ If yes, when most recently? MM-DD-YYYY

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: MM-DD-YYYY

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
- ☐ ADHD
- ☐ Hepatitis
- ☐ Hereditary problems
- ☐ Asthma
- ☐ Headaches
- ☐ Prolonged bleeding
- ☐ Sleep apnea
- ☐ Diabetes
- ☐ Heart murmur
- ☐ Heart problems
- ☐ H.I.V. Positive
- ☐ Other: _____

PARENT/GUARDIAN INFORMATION

(Dr / Mr / Mrs / Ms / Miss) Full name: _____

Address: _____

City: _____ Province: _____

Postal code: _____ Email: _____

Home phone number: _____

Work phone number: _____

Mobile phone number: _____

(Dr / Mr / Mrs / Ms / Miss) Full name: _____

Address: _____

City: _____ Province: _____

Postal code: _____ Email: _____

Home phone number: _____

Work phone number: _____

Mobile phone number: _____

Person(s) responsible for financial obligation: _____

Parental marital status (check one): ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Where did you *first* discover our clinic? e.g. Google > Website ... Referred by [name] 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 my child's clinical photos and x-rays for Dr. Kamelchuk's educational/teaching purposes
◯	◯	I consent to having 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(es): _____

sign here after printing this form

Parent/Guardian signature

Chart number: _____ *for clinic use*

INSURANCE INFORMATION

Insurance Plan 1 (please print):

Subscriber's Name: _____

Date of Birth: MM-DD-YYYY

Relationship to Patient: _____

Insurance Company: _____

Group / Policy ID # _____

Certificate / ID # _____

Insurance Plan 2 (please print):

Subscriber's Name: _____

Date of Birth: MM-DD-YYYY

Relationship to Patient: _____

Insurance Company: _____

Group / Policy ID # _____

Certificate / ID # _____