Dr. Lorne S. Kamelchuk*
D.D.S., M.Sc., D.Ortho., F.R.C.D.(C)

CHILD PATIENT PERSONAL INFORMATION

Consultation date:____________________ **Date of Birth:** ____________________

Patient's Name:____________________ **Sex:** O Female O Male

Patients Address:____________________ **Home Phone Number:**____________________

City: __________ **Province:** __________ **Postal Code:**____________________

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):

- O Thumb/finger sucking
- O Tonsils removed
- O Jaw joint problems
- O Injury to face or teeth
- O Speech/articulation problems
- O Grinding/clenching of teeth
- O Tongue and/or swallowing problems
- O 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):

- O Epilepsy or seizures
- O Hepatitis
- O Diabetes
- O Nickel/Metal allergy
- O Hereditary problems
- O Heart murmur
- O Anemia
- O Latex allergy
- O Asthma
- O Heart problems
- O Prolonged bleeding
- O Rheumatic fever
- O Headaches
- O H.I.V. Positive
- O Other: __________

PARENT/GUARDIAN INFORMATION

Mother's Name (Dr/Mrs/Ms/Miss):____________________ **Father's Name** (Dr/Mr):____________________

Address:____________________ **Address:**____________________

City:__________ **Province:**__________ **City:**__________ **Province:**__________

Postal Code:__________ **Email:**__________ **Postal Code:**__________ **Email:**__________

Home Phone Number:____________________ **Home Phone Number:**____________________

Work Phone Number:____________________ **Work Phone Number:**____________________

Mobile Phone Number:____________________ **Mobile Phone Number:**____________________

Person(s) responsible for financial obligation:____________________

Parental Marital Status (check one): O Single O Common Law O Married O Separated O Divorced O Widowed

Who may we thank for referring you?____________________ **Reason for today's visit:**____________________

YES	NO	
O	O	I consent to having Dr. Kamelchuk do a clinical orthodontic examination with diagnostic imaging.
O	O	I consent to the discretionary and anonymous use of my child's clinical photos and x-rays for Dr. Kamelchuk's educational/teaching purposes.
O	O	I consent to having reviewed Dr. Kamelchuk's privacy policy.

____
(Parent/Guardian Signature)

Chart Number:____________________

INSURANCE INFORMATION

Insurance Plan 1 (please print)	**Insurance Plan 2** (please print)
Employee's Name:	Employee's Name:
Company Name:	Company Name:
Insurance Company:	Insurance Company:
Group/Policy Number:	Group/Policy Number:
Certificate/I.D. Number:	Certificate/I.D. Number:
Date of Birth (MM/DD/YY):	Date of Birth (MM/DD/YY):
Relationship to Patient:	Relationship to Patient:

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