Renfroe Orthodontics

New Patient Welcome Questionnaire

WELCOME: .....

Our practice is here to provide our patients with the best orthodontic treatment available today. But, our patients are also our friends. If you would, please answer the questions below so that we may get to know you better.

What name (or nickname) do you like to be called by? .....
.....
What subject do you like most if attending school? .....
.....
.....
What are your your hobbies and what types of things do you like to collect? .....
.....
.....
.....
What type of sports do you like? .....
.....
.....
What type of movies do you like? .....
.....
.....
What kind of music do you like, and who are your favourite performers or groups?
.....
.....
What else do you like to do with your spare time? .....
.....
.....
Do you like travelling abroad? .....
Do you have any pets? If so, what kind? .....
.....
Kindly list the names of any of your friends or relatives who come to our office for orthodontic treatment. .....
.....

Please remember to bring this form when you are coming for your first appointment.
THANK YOU!

Orthodontic Acquaintance Form

Ronald A. Ramsay
The Renfroe Professional Centre
Welches Road
(246) 427-3651

Today's Date _____

Patient's Name _____

I prefer to be called _____

Birthdate _____ Age ____Sex ____

Home Address _____

_____

Home# _____ Wk # _____

E-Mail Address _____

Employer _____

Address _____

Occupation _____

How long there? _____

School/College/University _____

Whom may we thank for referring you?

_____

Other family members seen by us _____

General Dentist _____

Phone Number _____ Last Visit _____
Last procedure done_____

Person Responsible for the Account

_____

Relationship _____

Billing Address _____

_____

Home# _____ Wk# _____

Employer _____

Occupation _____

Best time to call _____

Dental Insurance Coverage ☐Yes☐ No

Dental Insurance Company

_____

Mother/Father's Name if <u>not</u> responsible for account. _____

Home Address _____

_____

Home# _____ Wk# _____

Names of siblings not seen by us:

_____

_____

In the event of an emergency whom should we contact? _____
Relationship _____ Home# _____ Wk# _____
Physician's Name _____
Telephone# _____ Last visit _____

PTO➔

Dental and Medical History

Dental History

What are your main concerns that you would like to have corrected by orthodontic treatment? _____
_____
_____
_____

Have you seen an orthodontist before? ___

Name_____Date _____

Have you discussed orthodontic treatment With your dentist? _____

Have you ever had an injury to your teeth, Face or chin? _____

Do you generally breathe through your mouth or through your nose? _____

Have you sucked thumb, fingers or tongue? _____Until what age? _____

Do you have any speech problems? ____

Have any family members had orthodontic treatment? _____ If so, which?
_____

Would you like to know more about tooth whitening? _____

If you could change something about the appearance of your teeth or your smile, what might it be? _____

Medical History

Are you currently under the care of a physician ☐Yes☐ No
Please explain _____
_____

Are you taking any medications?
☐Yes☐ No
Please list _____
_____
_____

Are you pregnant? ☐Yes☐ No #Wks ____

Are you allergic to latex ☐Yes☐ No

Are you allergic to any medication? _____
If so, which? _____

Have you ever had any of the following diseases or medical problems?

☐Abnormal Bleeding	☐Heart Surgery
☐Anemia	☐Hemophilia
☐Asthma	☐Hepatitis
☐Blood Transfusion	☐ High/Low Blood Pressure
☐Cancer	
☐Heart Murmur	☐HIV/AIDS
☐Heart Defect	☐Kidney Problems
☐Diabetes	☐Rheumatic fever
☐Shingles	☐Severe Headaches
☐Epilepsy	☐Drug/ Alcohol Abuse
☐Heart Attack	☐Sinus Problems
☐Stroke	☐Ulcers/Colitis
☐Difficulty Breathing	☐Frequent Headaches
☐Venereal Disease	☐Bone Disorders

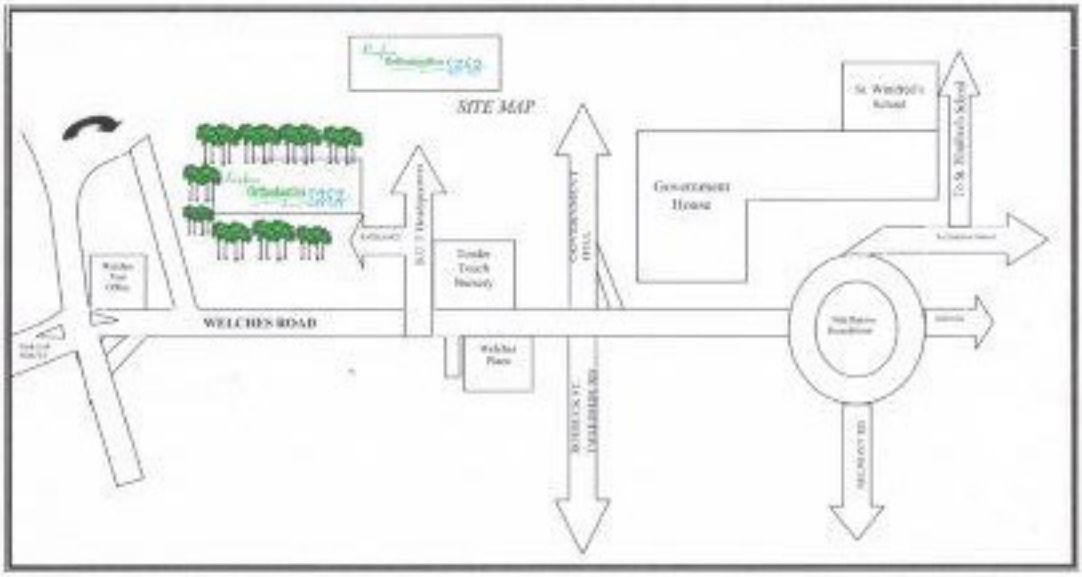
I understand that the information supplied on this form is correct to the best of my knowledge.
I authorize the orthodontic staff to perform any necessary dental services that I might need during diagnosis and treatment with my informed consent.

_____ _____
Signature Date

I understand that I am responsible for payment of services rendered.

_____ _____
Signature Date

Thank-you for filling out this form completely


SITE MAP
St. Winifred's School
Government House
WELCHES ROAD
Welches Place