ORTHODONTIC CONSULT QUESTIONNAIRE

Patient Information

Referring Dentist:

Name: ____
First Last

Birth Date: ____________________
Day Month Year

☐ Male ☐ Female

Address: ____

City /Prov/Postal Code: ______________________________________

Home Phone: ____________________ Work phone: ____________________

Cell Phone: ____________________

Email: ____

Best time and place to contact you: ______________________________

INSURANCE:

Member Name: _______________

Group Number: _______________

Plan Number: _______________

INSURANCE:

Member Name: _______________

Group Number: _______________

Plan Number: _______________

Family Physician: ______________________________________

Telephone: ____________________

List any medical concerns/illnesses/allergies or treatments you are receiving: ____

____

Patient Name ______________________________________

Dentist: ______________________________________

Telephone: ____________________

List any dental treatment concerns or treatment in progress:

____

____

____

Consult Initiated By

☐ Dentist Referred

☐ Parent/Guardian

☐ Spouse/Partner

☐ Self

Orthodontic Evaluation

Have you ever had a consultation with another Orthodontist? ☐ Yes ☐ No

If Yes:

Orthodontist Name ______________________________

Date: ______________________________

Outcome of prior Consultation/Treatment:

____

____

Patient/Parent Smile Evaluation

Describe what you currently like about your smile:

____

____

What would you not change:

____

____

Patient Name ______________________________

What would you like to accomplish with Orthodontics:

____

What concerns do you have regarding treatment:

____

Is there a specific time frame in which you would like to start/complete the treatment:

____

____

What might prevent you from going forward in the treatment:

____

Consultation Outcome:

☐ Estimate sent to Insurance ☐ Financing Required/Submitted

☐ Records Scheduled ☐ Follow Up Required

Date of Consultation: ______________________________