DR. VOHN ROSANG, INC.*

DR. VOHN ROSANG D.M.D, M.Cl.D., FRCD(C)
Certified Specialist in Orthodontics
Telephone: 655-7007 / 250-595-2334
WWW.ISLANDORTHODONTICS.CA

GENERAL INFORMATION

Please Complete and return to office day of appointment. **Date:** _______________

Patient's Name: Mr./Mrs./Ms.: ____

Patient likes to be called: ____________________________ Date of Birth:__________________________

Age:_________________ Sex:______________________

Address: ____

Postal Code:____________________________ Email:____

Telephone:_______________________________________ Business:________________________________

Occupation:____

Dentist:____ Doctor:_________________________________

Whom can we thank for referring you to see us?:____

Please complete the following if the patient is under age 18.

School:____ Grade:__________________________________

Hobbies & Sports:____

Father's name:__________________________________Occupation:______________________________

Employed by:_____________________________________ Telephone:_____________________________

Mother's Name:__________________________________Occupation:______________________________

Employed by: ___________________________________ Telephone:______________________________

Number of Children in Family:______________________ Ages & Sexes:__________________________

Has patient reached adolescent growth spurt?________________________

Have we had the opportunity to examine or treat another member of your family?____________________

DENTAL INSURANCE

We do not bill dental insurance companies or other third parties on patient's behalf. Accordingly we will expect that payment be received directly from patients as services are provided. We will be pleased to prepare reports and claims for you to submit to insurance companies upon receipt of payment for services rendered.

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GENERAL HEALTH

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Please check box if patient is affected by any of the following conditions:

□ Diabetes
□ Asthma or Other Respiratory Conditions
□ Rheumatic Fever
□ Convulsions
□ Kidney Disease
□ Heart Disease
□ Bone Disorder
□ Tuberculosis
□ Fainting and/or Dizziness
□ Frequent Headaches and/or Neckaches
□ Chronic Illness
□ Ever been hospitalized
□ Anemia
□ Bleeding Problems
□ Liver disease/Hepatitis
□ Nervous Conditions
□ Frequent Cold Sores or Canker Sores
□ Shortness of Breath or Chest Pains
□ High Blood Pressure
□ Cancer
□ Aids
□ Arthritis
□ Birth Defects
□ Breathes mainly through mouth
□ Tendency to cold/sore throats/ ear infection (Please circle)
□ Removal of Tonsils and adenoids. What age?___________________________
□ Allergies or Drug Sensitivities. Specify________________________________
□ Taking medication now. Specify_____________________________________
□ Using medication regularly. Specify_________________________________
□ Major Illness. Explain____
Women – Are you pregnant__________________ Due____________________

Use this space for any other conditions you think may be important:

Signature:____

If signed by other than patient, relationship to patient:______________________