PATIENT INFORMATION

Please print clearly

SURNAME: ____

FIRST NAME:______________________ PREFERRED NAME:______________________

DATE OF BIRTH:____/____/____ GENDER: MALE / FEMALE

ADDRESS:____

SUBURB:______________________________ POST CODE:______________________

MEDICARE CARD: ______________________ Individual Ref: ___ Valid to:___ /___

PARENT/GUARDIAN DETAILS:

FATHER –SURNAME:______________________GIVEN NAMES:______________________

ADDRESS:____

☎HOME:______________ ☎MOBILE:________________ ☎BUSINESS:__________________

☎MOBILE FOR SMS APPOINTMENT REMINDERS ONLY:______________________________

EMAIL:____

MOTHER- SURNAME:______________________GIVEN NAMES:______________________

ADDRESS:____

☎HOME:______________ ☎MOBILE:________________ ☎BUSINESS:__________________

EMAIL:____

☎MOBILE FOR SMS APPOINTMENT REMINDERS ONLY:______________________________

PERSON RESPONSIBLE FOR PAYMENT:

NAME:____

ADDRESS:____

☎HOME:______________ ☎MOBILE:________________ ☎BUSINESS:__________________

EMAIL:____

REFERRAL DETAILS: WERE YOU RECOMMENDED TO US?

IF YES, BY WHOM?____

WHEN WAS THE PATIENT'S LAST DENTAL CHECK-UP?______________________________

Signature______________________________**Date** ______________________________
(Parent/Guardian)

CONFIDENTIAL MEDICAL HISTORY

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic care. All information will be kept completely confidential.

Patient's full Name ______________________________ Date of Birth______________

Have any relatives had orthodontic treatment with us? ________ Name of relative______________________

Relationship ____

Name of school patient attends (if applicable) ______________________ Year_______________

General Dentist___________________ Medical Practitioner's Name (Doctor)____________________

Is the patient covered by health insurance? ________ If so, name of fund ______________________

Has the patient experienced any health problems? No ☐ Yes ☐ Explain ____________________

Any major change in the patient's health recently? No ☐ Yes ☐ Explain ____________________

Is the patient currently taking any medications? No ☐ Yes ☐ List ______________________

Has the patient ever been hospitalised? No ☐ Yes ☐ Explain ____________________

Has the patient's tonsils/adenoids been removed? No ☐ Yes ☐ Explain ____________________

Does the patient have any physical or mental impairments? No ☐ Yes ☐ Explain ____________________

Has the patient undergone any speech therapy? No ☐ Yes ☐ Explain____________________

Please indicate if you have a history of any of the following conditions **(please tick ☑ applicable):**

☐	Heart Murmur	☐	Haemophilia	☐	Tonsillitis	☐	Prolonged Bleeding
☐	Heart Surgery	☐	Blood Disease	☐	Frequent Headaches	☐	Hives/Rash
☐	Rheumatic Fever	☐	Arthritis	☐	Bone Disorders	☐	Drug Addiction
☐	Hay Fever	☐	Diabetes	☐	Asthma	☐	Nervous/Anxious
☐	Epilepsy	☐	Kidney Disease	☐	Mouth Breather	☐	Tuberculosis
☐	Endocrine Disorders	☐	Thyroid Problems	☐	Herpes (Fever Blisters)	☐	Fainting Episodes
☐	Growth Disorders	☐	Cancer	☐	Hepatitis (A)	☐	Hepatitis (B)
☐	Liver Disease	☐	AIDS	☐	H.I.V. Positive	☐	Hepatitis (C)
☐	Mitral Valve Prolapse	☐	Congenital Heart Disease	☐	Developmental Disorders	☐	**Allergies (specify):** ....

Do you clench/grind your teeth? No ☐ Yes ☐ When ______________________________
Do you have a nail biting habit? No ☐ Yes ☐
Does the patient suck thumb or fingers? No ☐ Yes ☐ If stopped, at what age? ________________

Have you ever had:

jaw/joint pain?	No ☐ Yes ☐	jaw/joint locking? No ☐ Yes ☐
jaw/joint grating noises?	No ☐ Yes ☐	jaw/joint clicking? No ☐ Yes ☐
jaw/joint popping?	No ☐ Yes ☐	ringing in ears? No ☐ Yes ☐

Since diagnostic x-rays may be indicated, in the case of a female patient,
is there presently a possibility of pregnancy? No ☐ Yes ☐

We may be required to share personal/medical information with members of the treating team or with external treating practitioners/professionals as part of the patient/s treatment.

Personal information will only be disclosed to those health care professionals directly involved in a patient's treatment & clinicians they have been referred to.

Clinicians you have been referred to may contact you to arrange a consultation.

I certify that the above medical history is accurate at this time. I acknowledge that it is my responsibility to inform this office of any changes. I also authorise this office to examine and initiate necessary dental services for me.

Signature______________________________________ **Date** ______________________