ADULT PATIENT INFORMATION

Please print clearly

SURNAME: _____

FIRST NAME:_____ PREFERRED NAME:_____

DATE OF BIRTH:___/___/___ GENDER: MALE / FEMALE / UNSPECIFIED

ADDRESS:_____

SUBURB:_____ POST CODE:_____

☎HOME:_____ ☎MOBILE:_____ ☎BUSINESS:_____

☎MOBILE FOR SMS APPOINTMENT REMINDERS ONLY:_____

EMAIL:_____

OCCUPATION:_____

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

PERSON RESPONSIBLE FOR PAYMENT:

NAME:_____

ADDRESS:_____

☎HOME:_____ ☎MOBILE:_____ ☎BUSINESS:_____

EMAIL:_____

REFERRAL DETAILS: WERE YOU RECOMMENDED TO US?

IF YES, BY WHOM?_____

WHEN WAS YOUR LAST DENTAL CHECK-UP?_____

PLEASE DESCRIBE YOUR CONCERNS/REASON FOR SEEKING AN ORTHODONTIC OPINION:_____

_____

Signature_____ **Date** _____

PLEASE TURN OVER

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.

Full Name _____ Date of Birth_____

Have any relatives had orthodontic treatment with us? _____Name of relative_____

Relationship _____

General Dentist_____ Medical Practitioner's Name (Doctor)_____

Are you covered by health insurance?_____ If so, name of fund _____

Do you have any health problems? No ☐ Yes ☐ Explain _____

Has there been any major change in your health recently? No ☐ Yes ☐ Explain _____

Are you currently taking any medications? No ☐ Yes ☐ List _____

Have you ever been hospitalised? No ☐ Yes ☐ Explain _____

Have your tonsils/adenoids been removed? No ☐ Yes ☐ Explain _____

Do you have any physical or mental impairments? No ☐ Yes ☐ Explain _____

Have you 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 ☐

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.

Consent for Clinical Photographs
I consent to the taking of clinical photographs for my medical records and treatment purposes only. No ☐ Yes ☐

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** _____