

The information obtained from this form will enable the Orthodontist to accurately assess each patient for any orthodontic treatment that may be required. If you have any questions about this form, please discuss these with our receptionist.

PATIENT INFORMATION

Title: (e.g. Mr, Ms)	Surname:	First name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Middle name(s):	Preferred name:
Date of birth: (DD/MM/YYYY)	Main language spoken at home:	Name of school or occupation:
Address:	Suburb:	Postcode:
Patient email:	Patient Mobile:	

Tick if you are the patient and the account holder. If so, you do not need to duplicate your details → however, please sign and date below*.

ACCOUNT RESPONSIBILITY

The parent, guardian, or other party responsible for paying the account should complete this section.

If there is more than one person responsible for the account, please ask our receptionist for an Account Responsibility form.

Title: (e.g. Mr, Mrs)	Surname:	First name:
Address:	Suburb:	Postcode:
Account holder mobile:	Relationship to patient: (e.g. Mum, Dad)	
Account holder email:		
*Account holder signature:		*Date:

OTHER CONTACTS

Please provide the details for at least one other contact and nominate an emergency contact.

Contact 1	Contact 2	Emergency Contact (tick one)
Name:	Name:	
Mobile:	Mobile:	<input type="checkbox"/> Account holder
Email:	Email:	<input type="checkbox"/> Contact 1
Relationship to patient:	Relationship to patient:	<input type="checkbox"/> Contact 2

APPOINTMENT REMINDERS

Please tick **two mobiles** and **two emails** to receive appointment reminders.

Patient mobile: <input type="checkbox"/> Yes	Account holder mobile: <input type="checkbox"/> Yes	Contact 1 mobile: <input type="checkbox"/> Yes	Contact 2 mobile: <input type="checkbox"/> Yes
Patient email: <input type="checkbox"/> Yes	Account holder email: <input type="checkbox"/> Yes	Contact 1 email: <input type="checkbox"/> Yes	Contact 2 email: <input type="checkbox"/> Yes

REFERRAL INFORMATION

Who referred you to this practice? (Please tick) <input type="checkbox"/> Dentist <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Google/social media <input type="checkbox"/> Other	Details of this referrer:
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Please turn over and complete the Medical History.

MEDICAL HISTORY

Dentist:	Practice, suburb:	Phone:
GP (doctor):	Practice, suburb:	Phone:

Do you have or have you had any of the following? Please answer every question by ticking YES or NO. If YES, please give details.

Asthma	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Allergies	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Blood pressure (high/low)	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Diabetes, epilepsy, thyroid issues	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Heart disease or rheumatic fever	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Kidney disease	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Serious operation	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Prolonged bleeding after injury	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Hepatitis A, B, or C	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Other infectious diseases	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Disability or impairments	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Mental health or behavioural issues	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Are you taking any medications?	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Have you had any adverse drug reactions?	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Are you pregnant?	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Are you under any treatment by your GP (doctor)?	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>
Any other health issues	<input type="checkbox"/> NO <input type="checkbox"/> YES	<i>Details:</i>

What do you see as the main concern with your teeth and/or bite?

Have you had any accidents or trauma to your teeth, mouth or jaw? YES NO

If YES, please give details, including year of accident and treatment provided:

Have you had any clicking, noises or pain in your jaw joints? YES NO

If YES, please give dates and details:

PRIVACY: This practice is committed to maintaining your personal health information. Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff or to other health professionals as considered necessary in the context of your treatment.

RECORDS: Your patient history, treatment records, X-rays and other material relevant to your treatment are to be kept at the practice. You may inspect or request copies of your treatment record at any time. If you request copies, a fee may apply.

Please sign this form as confirmation that you have read and understood our privacy policy and consent to the use of your health information in this way. ***If the patient is under 18, this MUST be signed by a parent or guardian**

Full Name:	<input type="checkbox"/> Patient over 18 yrs <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	Signature:	Date:
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