Patient Information Form

Patient Details

Surname: ______________________________ Given Names: ______________________________

Age: ______ Date of Birth: ______/______/__________ Gender: (M/ F) Occupation: ______________________

Address: ______________________________ Suburb: ____________________ Postcode: ______________

Mobile Phone: ______________________________ Email: ______________________________

Do you have Private Health Insurance?: (Y/ N) Name of Fund: ______________________________

Patient's Dentist: ______________________________ Practice: ______________________________

Address: ____

Patient's GP: ______________________________ Practice: ______________________________

Phone: ______________________________ Address: ______________________________

Person Reponisble for Account

☐ Self (Above Details)

If the account holder is different to the above please fill out the details below:

Full Name: ____ Phone: ______________________

Address: ______________________________ Suburb: ____________________ Postcode: ______________

Relationship to the patient: ☐ Parent ☐ Other, please specify: ______________________________

Emergency Contact if different to account holder:______________________________

Dental History

Please tick the main concerns with you teeth or jaws.

☐ Crooked Teeth	☐ Underbite	☐ Receding Jaw	☐ Crowding
☐ Potrusion	☐ Prominent Jaw	☐ Spacing	☐ Gum Problems
☐ Jaw Pain / Clicking	☐ Overbite	☐ Grinding	☐ Other

Please outline any problem more specifically if required: ______________________________

____

How frequently do you visit the dentist? ☐ Every 6 months ☐ Every 12 months ☐ Infrequently

Have you had any major dental work? (Y/ N) Please outline if yes: ______________________________

____

Have you had any previous orthodontic work? (Y/ N) Please outline if yes: ______________________________

____

Have you had any trauma (falls, knocks or bumps) to your teeth, or face? (Y/ N) Please outline when, how, what teeth and treatment : ____

____

Please provide an outline of your family dental/orthodontic history.

Siblings	Name	Age	Any problems with alignment of teeth	Any orthodontic treatment
1				
2				
3				
4				
Mother				
Father				

Medical History

Have you ever had any of the following?

- ☐ High Blood Pressure
- ☐ Asthma, chest or breathing problems
- ☐ Heart Ailment
- ☐ Thyroid Problems
- ☐ Rheumatic Fever
- ☐ Excessive bleeding or blood disorders
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Stomach or bowel problems (eg ulcer)
- ☐ AIDS/HIV
- ☐ Hepatitis
- ☐ Kidney Disease

Have you had any problems with dental treatment?______________________________

Are you taking any drugs, medicines or tablets? (Please list)______________________________

Are you presently under medical care?______________________________

List any other medicines or products you are allergic to (e.g.: Penicillin, Latex)______________________________

Have tonsils or adenoids been removed? (Y/ N) If so, at what age? Tonsils: ________ Adenoids: _________

Do you have: an artificial hip, heart valve or other prosthetic implant?______________________________

Female patients, are you pregnant? (Y/ N) Would you like to discuss any questions in private with the orthodontist? (Y/ N)

How Did You Hear About Us?

- ☐ Walk in
- ☐ Dentist refferal
- ☐ Patient refferal
- ☐ Staff refferal
- ☐ Yellow Pages
- ☐ Website
- ☐ Australian Dental Associtioan
- ☐ Australian Society of Orthodontists
- ☐ Other: ______________________________

☐ Please tick if you would not like to be included as part of online communications and email newsletter database.

Conditions and Consent

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the orthodontists and their staff.
I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service unless other arrangements have been made.
I understand that clinical images of the teeth may be used in a practice portfolio to showcase examples of dental work to other patients and my identity will remain anonymous.

Signature: ______________________________ Date: ______________________________

(Patient, legal guardian or authorized agent of patient)

(electronic submissions can sign at next appointment)