

Medical and Dental History Record

Information provided by you is considered 'Confidential' and is not released to any party without your prior consent

Patient's FIRST NAME	Patient's SURNAME	Date of Birth
Preferred Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	School (if applicable)

Briefly describe what concerns you most about your/ your child's teeth

Dentist who normally treats patient: School dentist Private dentist ⇨ Name: _____

How did you find out about the practice: Referral Family Friend YellowPages Internet Signage

Family members who have previously visited our practice (incl surname if different to above)

Mother/ Guardian's Name (for patients younger than 18 yrs)

Father/ Guardian's Name (for patients younger than 18 yrs)

Residential address
(Other than a PO Box)

Postal address
(Complete **ONLY** if different to residential above)

Contacts:

Phone (Mob) _____

Email: _____

Phone (H) _____

Phone (W) _____

Name of Account Holder _____

Relationship:

- Mother
 Father

Contact phone _____

Account address

Is patient transferring from **another Orthodontist** ?

Name & city: _____

For patients not transferring, has any previous orthodontic treatment been undertaken ?

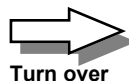
- Removable plates Fixed braces Tooth extractions ⇨

When ? _____

Is the patient covered by **Private Health Insurance** ?

(This information has no relevance to the treatment provided or its cost—it is used only in the event your insurer contacts us direct)

- BUPA Medibank Private Teacher's Health Westfund NIB AHM HCF
 Employer sponsored Other ⇨ _____



Turn over

I have confidential information that I don't wish to write down — I would prefer to discuss this with the Orthodontist (tick)

Please provide the following information for the person (you or your child) to be examined by the Orthodontist

	NO	YES	Provide details if you ticked YES
Are any tablets, pills or medicines (including over-the-counter and prescribed) being taken ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Is the patient being treated by a medical practitioner for any condition at present ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Are antibiotics required BEFORE any dental treatment ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Do you know if any allergies (including drug, nickel and latex) exist ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
FOR FEMALES ONLY ... are you pregnant or suspect you may be pregnant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Has there been any serious injuries involving the head, face, mouth or teeth ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Is there any family history of adult/ permanent teeth not developing ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Has there been any history of prolonged jaw joint (TMJ) pain, discomfort or clicking/ noises ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Please tick appropriate box if the patient has, or ever had, any of these medical conditions — then provide details below

	NO	YES		NO	YES		NO	YES
Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic implant incl. Shunt, limb etc	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve disorder incl. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Exposure with AIDS/ HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	Other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency (current or past)	<input type="checkbox"/>	<input type="checkbox"/>

Medical details incl. treating Practitioner's details where 'YES' ticked — include approximate year of condition diagnosis, its treatment and other relevant information

Declaration and Consent relating to medical/ dental information, examination and future review appointments

- I authorise the orthodontist to complete a preliminary examination of myself/ my child (the patient) and by doing so become responsible for the fee charged to complete this procedure—this fee must be paid on the day of examination. Where I fail to commit to paying this account or discuss an alternative arrangement I understand my personal details may be forwarded to a debt recovery agency and I will be responsible for all related costs
- I declare that the information provided in this medical/ dental history record is accurate and complete. I have not withheld any medical and dental information that relates to myself/ my child (the patient)
- I understand that I must advise the orthodontist if this medical/ dental history changes during the course of future treatment
- I consent to other health practitioners or related parties being consulted where it will assist in the provision of appropriate orthodontic advice and treatment
- I consent to this contact with other practitioners or parties being verbal, written and electronic (email). This contact may include the forwarding of X-Rays and other patient related documents by email, but only where the destination is known to be legitimate
- I, along with those who attend all appointments with me, understand and agree with the Practice Policy that personal cameras including mobile devices must not be used at any time to take photos while within the practice including waiting areas
- I understand this medical/ dental history record and all orthodontic treatment information is 'Confidential' and not made available to any other party unless governed by State or Federal laws or where authorised by me. All patient records are stored in a secure manner as required by State and Federal legislation
- I understand that security monitoring (CCTV) cameras are installed only in public spaces within the practice, they serve only for the protection of property and safety of those who are in attendance



Signature of parent, guardian or patient of 18 yrs or more

Date