



PATIENT INFORMATION

Patient's Name (first name) (last name)

Date of Birth Male Female

Home Address

Suburb Postcode

Home Phone Work Phone

Mobile

Email

Name of parent or guardian (if under 18 years old)

Name and ages of other children in family:

Name DOB.....

Name DOB.....

In case of an emergency who should we contact?

Name Phone

General Dentist

General Medical Practitioner.....

Whom may we thank for referring you to our practice?

Main reason for seeking orthodontic treatment.....

How do you think the patient will react to orthodontic treatment?

Excellent Good Fair Poor

Cooperation with the dentist is?

Excellent Good Fair Nervous

FINANCIAL INFORMATION FOR ACCOUNTS

Name of person responsible for this account (if other than self)

Relationship to Patient

Home Address (if different to patient)

Suburb Postcode

Home Phone Work Phone

Mobile

Email.....

Employer Occupation.....

Do you have any Orthodontic Extras Health Cover? Yes No

I understand that where appropriate, credit bureau reports may be obtained

Signature Date.....

Please complete page 2...

PATIENT'S MEDICAL AND DENTAL HISTORY

- Presently under medical care? Yes No
- Taking Medications? Yes No
- Previous hospitalisations? Yes No
- Activities limited? Yes No
- Emotional and behavioural problems? Yes No
- Tonsils removed? Yes No
- Adenoids removed? Yes No

Please briefly explain any YES answers

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Any current or past history of the following:

- High risk of HIV (Aids) Yes No
- Rheumatic fever Yes No
- Heart problems Yes No
- Blood pressure Yes No
- Bleeding problems Yes No
- Hepatitis Yes No
- Asthma Yes No
- Epilepsy Yes No
- Diabetes Yes No
- Birth defects Yes No
- Bone disorders Yes No
- Allergies Yes No

Have you experienced any of the following:

- Grinding Teeth Yes No
- Lip Sucking Yes No
- Thumb sucking Yes No
- Finger sucking Yes No
- Tongue thrusting Yes No
- Mouth breathing Yes No
- Abnormal swallowing Yes No

- Have you worn braces or plates before? Yes No
- Have you seen another Orthodontist? Yes No
- Has anyone in the family worn braces? Yes No
- Have any teeth been extracted? Yes No
- Are there any problems with the jaw joint? Yes No
- Have there been any injuries to the teeth or jaws? Yes No
- Do you have any gum disease? Yes No

When was the last time you had a dental check up?

If the patient is 15 years or younger, please answer the following:

- Permanent teeth came in: Average Early Late
- Emotional maturity is: Normal Adult-like Child-like
- Growth and development Slow Normal Advanced
- Female Menstrual period started Yes No Month.....Year

Doctor's Notes

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