PATIENT INFORMATION

AdvancedOrthodontics
The Technology Behind A Beautiful Smile

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

Date of Birth .... Male Female

Home Address...

Suburb .... Postcode ....

Home Phone .... Work Phone ....

Mobile ....

Email...

In case of an emergency who should we contact?

Name .... Phone ....

General Dentist ....

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

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...

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
Do you grind your teeth?	Yes	No
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 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

Consultation Notes...

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