Patient details

401 Gympie Road
Strathpine Queensland 4500
Telephone 07 3889 8355
Facsimile 07 3889 8377

1304 Samford Road
Ferny Grove Queensland 4055
Telephone 07 3851 0666
Facsimile 07 3351 8044

Orthodontics for Children and Adults

To assist us in your orthodontic treatment would you please answer the following questions.

Patient details

Name of patient _____ Date of birth _____

Address _____

_____

Telephone (home) _____ (work) _____ (mobile) _____

Parent/Guardian details

Father's full name _____

Telephone (home) _____ (work) _____ (mobile) _____

Mother's full name _____

Telephone (home) _____ (work) _____ (mobile) _____

Email address _____

If someone else is responsible for the account, what is their name and address?

_____

Additional information

Are you covered for Dental Health Insurance? ○ No ○ Yes If so which fund? _____

Who is the patient's dentist and when were they last seen? _____

Did someone recommend our practice to you? _____

Has the patient ever had any falls, accidents or operations involving the mouth or teeth? If yes, please explain:

_____

Has the patient ever sucked his/her thumb or fingers? ○ No ○ Yes Has this stopped? ○ No ○ Yes At what age? _____

Does the patient have any difficulty in breathing through the nose? ○ No ○ Yes

Has the patient ever experienced any tooth clenching/grinding at night, or pain/clicking/locking of jaw joints?

Please circle whichever apply and provide details. _____

Has the patient ever had orthodontic treatment before? ○ No ○ Yes

What is your main concern in seeking this appointment?

_____

please turn overleaf

Medical information

1. Is the patient under the care of a medical practitioner for any reason?

   If so, for what reason and who is the medical practitioner? _____

   _____

2. Is the patient taking any medication? ○ No ○ Yes If so, what is it and what is it for?

   _____

3. Has the patient ever had any of the following. If yes, please provide details.

Severe chest pain ○ No ○ Yes _____

Heart disorder of any kind ○ No ○ Yes _____

High or low blood pressure ○ No ○ Yes _____

Rheumatic fever ○ No ○ Yes _____

Prolonged bleeding, haemophilia ○ No ○ Yes _____

Asthma ○ No ○ Yes _____

Hepatitis ○ No ○ Yes _____

Diabetes ○ No ○ Yes _____

Disorders of other glands (eg thyroid) ○ No ○ Yes _____

Epilepsy ○ No ○ Yes _____

Treatment for cancer ○ No ○ Yes _____

Tonsils or adenoids removed ○ No ○ Yes _____

Cardiac surgery/pacemaker ○ No ○ Yes _____

4. Does the patient suffer from any other illness or disorder? ○ No ○ Yes

   If yes, please specify _____

5. Is the patient allergic to: ○ Aspirin ○ Penicillin ○ Iodine ○ Sulphur ○ Other _____

6. Is the patient pregnant? ○ No ○ Yes How many months? _____

7. AIDS, HIV and Hepatitis virus can be transmitted through blood and saliva. High risk categories have been identified as:
   - homosexuals and bisexuals
   - recipients of blood or blood products
   - patients who have contracted Hepatitis B
   - users of intravenous drugs of addiction
   - sexual partners of any of the aforementioned

   Do you consider yourself or your child to be in a high risk category? ○ No ○ Yes

8. Is there anything you would like to speak about in private with the orthodontist? ○ No ○ Yes

Signature of responsible person completing this form. _____

All information will be treated with complete professional confidentiality.