Straight Smile Centre

# Welcome To Our Office

## Personal Information:

Title _____

First Name _____ Surname _____

Preferred Name _____ Male/Female _____

Date of Birth _____ Age _____ Occupation/School _____

Are you Aboriginal/Torres Strait Islander? Y/N

Is English your second language? If so, what other language do you speak?_____

Home Address _____ Phone (H) _____

_____ Phone (W)_____

_____ postcode_____ Phone (M) _____

Email Address _____

Hobbies/Interests (optional) _____

Are you on Facebook? Y / N Check out our page!!

## Emergency contact details:

Title _____

First Name _____ Surname _____

Phone (H) _____ Phone (M) _____

## Account Information (Parent/Guardian)

Is the patient responsible for the account? Y / N

If **NO**, please continue with this section:

Title _____ Relationship to Patient _____

First Name _____ Surname _____

Preferred Name _____ Male/Female _____

Home Address _____ Phone (H) _____

_____Postcode_____ Phone (M) _____

Phone (W) _____

Email Address _____

## Health Insurance Information

Do you have private health insurance? Y / N

Fund Name _____

Who is your GP? _____

**PTO** ⟶

## Referral Information

Is this your first visit to an orthodontic practice? Y / N

How did you first hear about our practice? _____

Do you have siblings or family members who also attend this practice (please list names)?

_____

Who is your dentist? _____

Date of Last Visit with dentist?_____

## Health Information

| Do you suffer from: | Y | N |
|---|---|---|
| ➢ Heart/Vascular Disorder | ☐ | ☐ |
| ➢ Blood Disease/Bleeder | ☐ | ☐ |
| ➢ Blood Pressure Problem | ☐ | ☐ |
| ➢ Rheumatic Fever | ☐ | ☐ |
| ➢ Arthritis | ☐ | ☐ |
| ➢ Diabetes | ☐ | ☐ |
| ➢ Liver or Kidney Disease | ☐ | ☐ |
| ➢ Asthma | ☐ | ☐ |
| ➢ Epilepsy | ☐ | ☐ |
| ➢ Cold Sores | ☐ | ☐ |
| ➢ Hepatitis or HIV | ☐ | ☐ |
| ➢ Allergy/Hypersensitivity | ☐ | ☐ |
| ➢ Special needs (eg sensory, autism, anxiety) | ☐ | ☐ |
| ➢ Is there a possibility that you could be pregnant? | ☐ | ☐ |
| ➢ Do you require antibiotic cover for dental procedures? | ☐ | ☐ |
| ➢ Other (please give details) | ☐ | ☐ |

_____

_____

Current medications (please give details)

_____

_____

For particular appointments, we may take a small deposit to secure the appointment. In these situations, if you need to cancel or change your appointment we require 48 hour's notice otherwise this deposit will be retained as a late cancellation fee.

**Signature** _____ **Relation to Patient** _____ **Date**_____