PATIENT HISTORY FORM

FULL NAME: ……..
Please circle: Dr/Mr/Mrs/Ms/Miss/Master

Date of Birth: / / Age: Years & Months

Home Address: Postcode:

Telephone: Home: Work Ph: Mobile:

Email Address:

Primary/High School/College:

Family Dentist:

Family Medical Practitioner:

School Dentist:

School Dental Clinic:

Who referred you to us?
❑Dentist ❑Family ❑Friend – Referrer's Name: _____
❑Internet – please circle:
Google / Our Website / Yahoo7 / Yellow Pages Online / Other_____

PARENT DETAILS: (if patient is under 18 years):

Father:

Address (as above/other): Post Code:

Work Ph: Mobile:

Email:

Mother:

Address (as above/other): Post Code:

Work Ph: Mobile:

Email:

PARTY RESPONSIBLE FOR FEES:

Account Names/s:

Name of Private Health Fund/Insurance Co.:

PREVIOUS DENTAL/ORTHODONTIC HISTORY:

Most recent Dental Check-up (when):

Previous Orthodontic Consultations:

Treatment (eg: plates/braces):

Extraction of Teeth:

Trauma:
Have any teeth been subjected to trauma previously? If yes, please give details (when):

Please circle as appropriate:

Mouth Breathing: Always/Sometimes/Never

Nose Breathing Problems: Yes/No

Thumb/Finger Sucking: Never/Current/Given up at age years.

MEDICAL HISTORY (Please tick if applicable)

❑ Asthma ❑ Birth defects ❑ Bleeding disorders ❑ Bone disorders
❑ Diabetes ❑ Emotional problems ❑ Epilepsy ❑ Growth problems
❑ Heart murmur ❑ Heart disease ❑ Hepatitis ❑ High blood pressure
❑ Headaches/Migraines ❑ HIV / AIDS ❑ Kidney disease
❑ Allergies _____
❑ Other _____
❑ Current Medication _____
Is there Is any medical conditions/concerns you wish to discuss in private? ❑Yes ❑No

AUTHORITY TO REQUEST/REFER RECORDS TO HEALTH CARE PROVIDER

You/your child's privacy is important to us. However, in some cases to provide the best possible treatment without repeating procedures, we may need to request records from your previous or current dentist or specialist to assist with your orthodontic treatment planning. We also correspond and forward x-rays when required, with your dentist or other specialists for treatment planning. During your treatment, we may need to refer you to other specialists. To ensure compliance with Federal and State Privacy Legislation we require your signed consent to work with other health care professionals.

Parent/patient signature……Name……Date…….....

AUTHORITY AND ACKNOWLEDGEMENT

West Lakes/Glenelg/Nuriootpa

I/WE.....
Self/The Parent(s)

hereby authorise you to provide orthodontic services to myself/my/our child

……..

as you consider necessary or desirable and as agreed to by myself/ourselves. I/WE hereby agree to be responsible for the payment of your professional fees for such services, in accordance with the agreed schedule.

"In the case where both parents or guardians of the patient sign this form it is herby acknowledged and agreed by such parents or guardians that they accept and undertake joint and several liability for the professional fees and expenses of and incidental to the dental services rendered to the patient, not withstanding whether the account for such fees and expenses is in one or both of names of such parents or guardians."

TODAY'S DATE.....……

……
SIGNATURE OF PARENT/ GUARDIAN/SELF

Thank you for taking the first step towards a sensational smile!