Orthodontics Sydney Wide

Straight teeth - Winning Smiles - Personal Care

PATIENT INFORMATION & MEDICAL HISTORY FORM

Title: ____________ Patient's Surname ____________________ First Name________________________ Middle Initial____

Gender: ❑ Male ❑ Female Date of Birth ___/___ / ___ Age: __________

Home Address ____ Post Code______

Telephone: Home - ____________________ Work - __________________ Mobile - _________________________

E-mail ____ Primary language spoken at home: _________________________

Patient School/University/Occupation: ____

Other family members in the practice ____

Patient's Dentist name & address ____

Has the patient had a check up and/or clean recently? YES / NO Patient's Doctor _______________________________

Does the patient have health fund for Orthodontics? YES / NO Which Fund? __________________ Member ID: __________

WHO CAN WE THANK FOR REFERRING YOU?

Dental Practitioner
- ❑ Dentist
- ❑ Dental therapist/hygienist
- ❑ Oral Surgeon
- ❑ Periodontist
- ❑ Paedodontist

Doctor Name:

____

Other: __________________

Internet
- ❑ Our website
- ❑ Facebook
- ❑ Internet (**Please circle**)

Google / Bing / Yahoo

Other _______________

- ❑ Invisalign website

Word of mouth
- ❑ Patient - Friend

Name ________________

- ❑ Patient - Family member

Name ________________

Advertisement
- ❑ School program /advertisement

Specify _______________

- ❑ Signage

Specify _______________

- ❑ Sponsorship

PARENT DETAILS (IF UNDER 18YRS OLD)

Correspondence to be sent to: Father ❑ Mother ❑ Both ❑

Father: Title: ______ Full Name: _______________________________________ Next of Kin ❑

Address (As above / Other) ____ Post code: ______

Home phone (As above/other) _____________________________________ Work phone: ____________________________

Mobile: ____ Email: ____

Mother: Title: ______ Full Name: _______________________________________ Next of Kin ❑

Address (As above / Other) ____Post code: _________

Home phone (As above / Other) ____ Work phone: __________________________

Mobile: ____ Email: ____

EMERGENCY CONTACT:

Name: ____________________________ Contact: _________________ Relationship to Patient: ______________

PERSON RESPONSIBLE FOR FEES:

❑ Self / ❑ Other – Relationship to Patient _______________________________

Contact details **if not self**: Name (include title) ____

Address ____

Mobile Phone__________________________________ Home Phone____________________ Work Phone____________

PATIENT DENTAL HISTORY

Have any teeth been extracted? YES / NO / UNSURE Any missing permanent teeth? YES / NO / UNSURE

History of trauma to teeth, mouth or face ____

Past or present habits (e.g. thumb / finger sucking, tongue thrusting, lip biting, etc.) __________________________________

Past orthodontic consultation YES / NO Past orthodontic treatment (e.g. plates / braces) ____________________________

Other significant dental history (e.g. missing teeth, root canal, TMJ) ____

Main concerns about patient's teeth? ____

PATIENT'S MEDICAL HISTORY : (PLEASE TICK WHERE APPLICABLE)

❑ Asthma ❑ Bleeding disorders ❑ Bone disorders
❑ Diabetes ❑ Anxiety ❑ Epilepsy ❑ Growth problems
❑ Heart murmur ❑ Heart disease ❑ Hepatitis ❑ High blood pressure
❑ Headaches/Migraines ❑ HIV / AIDS ❑ Kidney disease ❑ Allergies________________________________
❑ Other____
❑ Current Medication ____
❑ Adverse Reactions to medications: (explain) ____

To the best of my knowledge, the information provided on this form is complete and correct.

Patient / Parent Signature ____________________ Name ______________________________ Date ______________

PRIVACY POLICY

We consider the protection of your privacy and personal information to be a high priority. Therefore, we realise that it is important that you are aware of why we collect, how we use and to whom we may disclose your information.

The policy of our practice is to follow these procedures:

- The information collected will be used for the purposes of providing treatment to you. Personal information such as your name, address and other details will be used for the purpose of accounts and payments and writing to you about your treatment and our services.
- We may disclose your health information to other health care professionals or require it from them if necessary for your treatment. In that event, disclosure of your personal details will be minimised.
- We may also use parts of your health information for research purposes in study groups or at seminars and lectures as this may be of benefit to other patients. Your personal identity will not be disclosed.
- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

We respect your privacy and this information will be held in the strictest confidence.

Please sign here as confirmation that you understand and consent to our privacy policy.

Patient / Parent Signature ____________________ Name ______________________________ Date ______________

AUTHORITY TO REQUEST / REFER RECORDS TO HEALTH CARE PROVIDERS

We may need to request records from your previous or current dentist or specialist to assist with your orthodontic treatment planning. We also correspond with and forward x-rays to your dentist or other specialists for treatment planning when required. 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.

Patient / Parent Signature ____________________ Name ______________________________ Date ______________

PHOTO RELEASE CONSENT (USE OF PHOTOS WOULD BE DISCUSSED BEFORE POSTING)

I hereby give permission to Orthodontics Sydney Wide to use my name and photographic likeness in all forms and media for advertising and exposition displays.

Patient / Parent Signature ____________________ Name ______________________________ Date ______________

HURSTVILLE
Suite 503, 12-14
Ormonde Parade
02 9570 8133

PARRAMATTA
Suite 1, level 5,
35 Smith Street
02 9633 4466

EPPING
Suite 109,
2 Pembroke Street
02 9869 7666