

Thank you for choosing our Orthodontic Practice

To help us provide the best possible evaluation of your treatment needs, please answer questions on **BOTH SIDES** of this form.

Title: Miss Ms Mrs Mr Master Dr Other

Surname: _____ Given Name: _____ Preferred Name: _____

Residential Address: _____

Postal Address if different to above: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Fax: _____ Email: _____ Date of Birth: _____

Occupation: _____ Employer: _____

IF PATIENT UNDER 18 YEARS OF AGE, PLEASE COMPLETE THIS SECTION

Mothers Full Name: _____ Occupation: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Fathers Full Name: _____ Occupation: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Person responsible for paying accounts: _____

Address: (if different from above) _____

Your general dentist: _____ Date of last check up: _____

Who recommended us to you? _____

Do you have dental cover? (If yes, which one?) _____

Please turn over page

MEDICAL INFORMATION

Do you have or ever had:

- | | | | | |
|--|--------------------------|----|--------------------------|-----|
| Rheumatic Fever | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Hepatitis | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Heart Problems (eg: Murmur, Valves) | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Allergic Reactions (eg: Medications) | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Nasal Problems (eg: Adenoids, Sinuses) | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Injuries to Jaws or Mouth | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Any Serious Illnesses | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Are you on any medication | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Are you having medical treatment | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Are you a smoker? | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |
| Ladies, are you pregnant or hoping to be so? | <input type="checkbox"/> | No | <input type="checkbox"/> | Yes |

ORTHODONTIC INFORMATION

Have you had previous orthodontic opinion/treatment No Yes

In your own words, what concerns you about your teeth? OR What is the purpose of your visit today?

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Who is concerned about your teeth and/or jaws?

- Yourself Your family Your dentist

**Please note that our policy is to receive payment on the day of treatment.
We accept cash, Eftpos, Cheque, Visa, Mastercard, Bankcard, Diners and Amex.**

SIGNATURE: _____ **DATE:** _____

If under 18 years of age, the parent/guardian must sign this form.

Thank you for providing this important confidential information.