

PATIENT'S NAME _____
(Family Name) (First Name)

DATE OF BIRTH _____ AGE: _____

ADDRESS _____ PHONE (H) _____
_____ (W) _____
_____ POSTCODE _____ (M) _____

E-MAIL ADDRESS: _____

GENERAL DENTIST: _____

GENERAL PRACTICIONER: (DOCTOR) _____ PHONE NUMBER: _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNTS: _____

ADDRESS: (If different from above) _____

DO YOU HAVE PRIVATE HEALTH INSURANCE? (If Yes, which one) _____

DOES IT INCLUDE DENTAL/ORTHODONTICS? (If Yes, which one) _____

1. Are you currently under the care of a medical practitioner or taking any medication?

If yes, please outline: _____

2. Please **tick** if you have currently or have had any of the following:

MEDICAL

- A heart disorder
- Bleeding disorder
- Diabetes
- Asthma
- Rheumatic Fever
- AIDS or related disease
- Hepatitis
- Females, are you pregnant?
- NLA (Natural Latex Allergy)
- Sensitivity to Latex/Rubber Products

Any other illness or disability or allergy? _____

DENTAL

- Fluoride treatment.
- Breathe predominantly through the mouth
- Treatment for any gum disease
If yes, is it under control? Yes No
- Have any permanent teeth:-
 - Been extracted ? Had root treatment
 - Been injured or chipped ?

3. Have you had any pain or clicking in the jaw joint ? If so please outline: _____

4. Please write down the main orthodontic or facial concern/s that prompted you to seek this appointment.

Do you consent to receiving an SMS from us to confirm your appointment and to email correspondence?

Yes No

PLEASE PROCEED TO PAGE 2

IF YOU SUBSEQUENTLY DEVELOP ANY ILLNESS PLEASE KEEP US INFORMED.

5. Would you please let us know **how** you found us? We appreciate and like to **thank** those who refer to us. Feel free to tick all those below that are appropriate.

- Internet Search/ website
- Family member/Friend Name: _____
- General Dentist. Name: _____
- Another Orthodontist. Name: _____
- Print Advertising: _____
- Other _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

It is part of our Privacy Policy to not give out any of your personal information without your consent. If you would like to nominate anyone other than yourself who you permit to have access to your information please do so below. Persons not nominated will not be able to obtain any information including appointment times and financial details.

NAME	RELATIONSHIP TO THE PATIENT	APPOINTMENTS	FINANCIAL
_____		YES / NO	YES / NO
_____		YES / NO	YES / NO
_____		YES / NO	YES / NO

We make every effort to ensure the **privacy** of your details. Please ask Reception if you wish to read our Privacy Policy.

SIGNATURE: _____ DATE: _____

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