Welcome to Toowong orthodontics

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

DATE OF BIRTH _____ **AGE:** _____

ADDRESS _____ **PHONE** (H) _____

_____ (W) _____

_____ **POSTCODE** _____ (M)_____

E-MAIL ADDRESS:_____

FATHER'S NAME:_____ **MOTHER'S NAME**:_____

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 any of the following:

MEDICAL

- ☐ A heart disorder
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ AIDS or related disease
- ☐ Hepatitis
- ☐ Females, are you pregnant?

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 ?

Any other illness, disability or allergy? Eg. Autism _____

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 Name _____
- ☐ Friend Name _____
- ☐ General Dentist. Name _____
- ☐ Another Orthodontist Name _____
- ☐ Print Advertising. Could you list which? _____
- ☐ Other _____

EMERGENCY CONTACT:_____PHONE NUMBER:_____

It is part of our Privacy Policy to not give out any personal information without your consent. If you would like to nominate anyone other than yourself who you permit to have access to the patient's 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: _____

UPDATED: _____ NAME: _____ SIGNATURE: _____