Welcome to Toowong orthodontics

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

DATE OF BIRTH _____ AGE: _____ SEX: Male Female Other

ADDRESS _____ PHONE (M) _____

_____ POSTCODE _____ (W) _____

EMAIL ADDRESS:_____

PARENT'S NAME: _____ PARENT'S NAME: _____

GENERAL DENTIST: _____ SCHOOL: _____

GENERAL PRACTITIONER (DOCTOR): _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNTS: _____

RESPONSIBLE PARTY DATE OF BIRTH: _____

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		Dental
A heart disorder	Are you pregnant?	Fluoride Treatment
Bleeding Disorder	NLA (Natural Latex	Breathe predominantly through the mouth
Diabetes	Allergy)	Treatment for any gum disease
Asthma	Sensitivity to	If yes, is it under control? YES NO
Rheumatic Fever	Latex/Rubber	Have any permanent teeth:
AIDS or related disease	Products	Been extracted
Hepatitis		Had root treatment
		Been injured or chipped

Any other illness or allergy or disability (e.g. intellectual) ?_____

If yes, do you carry an Epipen for your allergy? YES NO

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

_____

IF YOU SUBSEQUENTLY DEVELOP ANY ILLNESS PLEASE KEEP US INFORMED.

Please proceeed to Page 2

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A Level 2, Toowong Terraces, 31 Sherwood Rd, Toowong, QLD 4066
ABN 77 846 742 419
toowongorthodontics.com.au

care to smile

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

_____

_____

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

Yes No

6. Do you consent to participating in photo opportunities for our social media platforms?

Yes No

7. Would you please let us know **how** you found us?

_____

We appreciate and like to **thank** those who refer to us.

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

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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