PATIENT INFORMATION FORM

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PERSONAL DETAILS

Patient's name _____ Preferred name _____

Patient's postal address _____

_____ Postcode _____

Phone number _____ Date of birth _____

Email address _____ Gender M F Other

How did you hear about us? _____

Dentist's name _____

Do you have Health Insurance that covers Orthodontics? YES____NO____NOT SURE____

Doctor's name _____

Payer's name (Person responsible for payment of account)_____

Payer's address _____

If under 18: Age _____

School _____

Hobbies _____

Sports _____

Sibling names & ages _____

_____

_____

Father's name _____

Work phone _____

Home phone _____

Mother's name _____

Work phone _____

Home phone _____

MEDICAL HISTORY

Y N 1. Does the patient have a health problem?

If YES please list _____

Y N 2. Is there a history of serious illness, accident or operation?

If YES please list _____

Y N 3. Is the patient under a doctor's care for any problem at this time?

Y N 4. Is the patient taking any medication?

If YES please list _____

Y N 5. Does the patient have any allergies or drug sensitivities?

If YES please list _____

DENTAL HISTORY

Y N 1. Has the patient had an orthodontic consultation previously?

Y N 2. Has the patient had any previous orthodontic treatment?

Y N 3. Has the patient had any injury to the teeth? (Baby or permanent teeth)

If YES please list what & when _____

Y N 4. Has the patient had any injury to the face, jaws or chin?

Y N 5. Has the patient had any cysts or tumours of the jaws or gums?

Y N 6. Have you been informed of any missing or extra permanent teeth?

Y N 7. Does the patient suck fingers or thumb, or have a similar habit?

If YES please list _____

8. Date of last dental examination _____

9. Reason for seeking treatment _____

Signature _____ Date _____

MEDICAL CHECKLIST:

Please tick if the patient has, or ever had, any of the following?

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bone disorders
- ☐ Cancer or tumour
- ☐ Cleft palate
- ☐ Diabetes
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy or convulsions
- ☐ Fainting or dizziness
- ☐ Hearing problems
- ☐ Heart diseases or murmur
- ☐ HIV or AIDS
- ☐ High risk group for AIDS
- ☐ Joint problems or pain
- ☐ Kidney problems
- ☐ Learning disabilities
- ☐ Rheumatic fever
- ☐ Sleep apnoea/Snoring
- ☐ Speech problems
- ☐ Syndromes
- ☐ Tonsillitis/Adenoids
- ☐ Tuberculosis

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