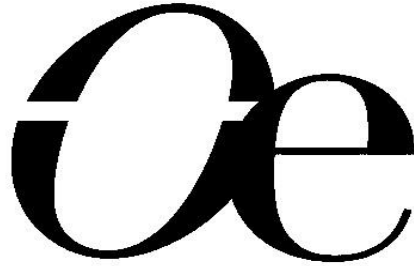


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e x c l u s i v e l y

CONFIDENTIAL PATIENT QUESTIONNAIRE

PATIENT DETAILS

Title _____ Surname _____ First Name _____ Middle Name _____

Date of Birth (dd/mm/yy) _____

Home Address _____ post code _____

Postal Address _____ post code _____

Telephone _____ Mobile _____ Home _____ Work _____

SMS appointment reminders? YES/NO Mobile number if different from above _____

Email address (Doctor's reports are emailed) _____

Preferred phone number to call during business hours: HOME/WORK/MOBILE

Name of school or occupation _____

Who referred you to our practice? _____

Has previous orthodontic consultation been sought? YES/NO Details _____

Names of other members of the family treated by our practice _____

Health Fund? YES/NO Name _____

DENTAL HISTORY

Name of Dentist _____

Have orthodontic appliances been worn previously? _____

How many times a day are teeth brushed? [] Not at all [] Once [] Twice [] More than twice

Are teeth flossed? YES/NO

Is the patient prepared to wear fixed appliances (braces) if necessary? YES/NO

DENTAL TRAUMA

Have any accidents been suffered causing:

[] tooth displacement/loss/damage [] tooth discolouration [] Facial fractures/jaw joint probs

ORTHODONTIC CONCERNS

[] Crowding or irregular teeth [] Chewing problems [] Speech defect

[] Thumb/finger sucking habit [] Missing teeth [] Grinding/Clenching

[] Clicking sounds from joints [] Jaw or facial pain [] Facial appearance

[] The concern of the referring dentist

/MEDICAL INFORMATION

Medical Practitioner Name _____ tel number _____

Does the patient take medication? YES/NO Please list _____

Does the patient have any allergies? YES/NO Please specify _____

Relevant medical history _____

Females: Are you pregnant? YES/NO

HEALTH WARNINGS - Have any medical problems been experienced in the following areas:

- Rheumatic fever/Heart murmur Heart valve/ Heart damage HIV/AIDS
- Heart attack/Angina / Stroke Heart surgery/Pacemaker High blood pressure
- Epilepsy Thyroid Diabetes
- Tuberculosis Asthma/Hay fever Arthritis
- Radiotherapy/Chemotherapy Kidney/Liver/Lung disorder Excessive bleeding
- Physical/Psychological disability Cleft lip or palate Hepatitis B or C
- Speech, hearing or sight problems
- Other - pls specify _____

CHILDREN AND TEENAGERS

GROWTH AND DEVELOPMENT INFORMATION

Has there been any recent rapid growth? YES/NO How much? _____

Father's Height? _____ Mothers Height? _____

Have any facial or dental characteristics been inherited? _____

Females: Has Menstruation begun? YES/NO If yes, when _____

SOCIAL INFORMATION

Parent/Guardian: Title _____ Surname _____ First Name _____
Relationship to patient _____

Parent/Guardian: Title _____ Surname _____ First Name _____
Relationship to patient _____

Patient lives with BOTH PARENTS/ MOTHER / FATHER

ACCOUNT DETAILS - Note: Interest and additional fees may be charged in association with or for the recovery of bad debts.

Person responsible for fees

Title _____ Surname _____ First Name _____

Business/Employer Name/Address _____

Home Address _____ post code _____

Mobile _____ Home _____ Work _____ Fax _____

Signature of person responsible for fees _____

PLEASE SIGN AND DATE TO CONFIRM ALL DETAILS PROVIDED ARE TRUE AND CORRECT

SIGNATURE _____ DATE _____

ORTHODONTIST'S SIGNATURE _____