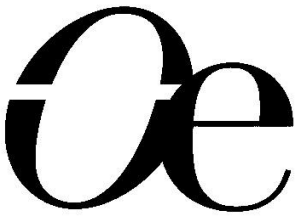
orthodontics



exclusively

CONFIDENTIAL PATIENT QUESTIONNAIRE

Please note, the consultation fee will range between $205.00 for consultation, or up to $550.00 depending on the records taken. This fee is payable on the day. Please note that if the appointment is cancelled with less than 48 hours notice, a 50% cancellation fee may apply.

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 _____

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 _____