SCOPE Orthodontics

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PATIENT DETAILS (TO BE COMPLETED BY A PARENT / GUARDIAN IF THE PATIENT IS UNDER 18 YEARS OF AGE)

In order to provide you with the highest standard of orthodontic care, it is important to know the patients medical and dental history, as these could affect the success of the treatment. If you have any questions associated with the information we collect from you and hold in your records please do not hesitate to ask us. We are acting in your best interest at all times. Please read our privacy policy-"We Respect Your Privacy" for further information.

The Patient

Title________ **Last Name** ________________________ **First Name** ________________________

Home address____**Postcode**______________

Date of Birth____________**Female/Male**_______ **School (if applicable)** ________________________

Telephone: Mobile ____________________ **Home**__________________ **Work** __________________

Name/s of any other family members who have attended the practice____________________________

What is your main reason for seeking this consultation__________________________________

Whom may we thank for your referral____

Name of your general dentist____

Practice Name/Location____

Name of your family doctor________________________**Address or phone No** ____________________

For the Parent/Guardian

Parent 1: ____Phone No__________________

Parent 2: ____Phone No__________________

Guardian: ____Phone No__________________

Email address____

Person responsible for payment of accounts

Name in full ____Phone No__________________

Address ____

Signature ____

Private Health Fund (if applicable) ____

PATIENT - MEDICAL AND DENTAL HISTORY – please indicate if you have confidential information that you want to discuss with the Orthodontist and not record on this form. ☐ Yes ☐ No

Has your child commenced puberty? ☐ Yes ☐ No

Has the patient inherited any facial or dental characteristics? If yes, please detail__________________

____

Does the patient take any daily medication? (Including prescribed, over the counter or naturopathic/herbal)?

If yes, please detail____

Any allergy to any medicines, chemicals or other substances (rubber,latex,antibiotics,peanuts etc)? ☐ Yes ☐ No

If yes, please detail____

____

Please tick ONLY if the patient has, or has ever had, any of the following medical conditions

- ☐ Heart Disease or complaint
- ☐ Heart murmur / Rheumatic Fever
- ☐ A.D.H.D.
- ☐ Epilepsy
- ☐ Asthma
- ☐ Diabetes
- ☐ Hepatitis A, B or C
- ☐ Arthritis
- ☐ Liver problems
- ☐ Kidney problems
- ☐ Bleeding problems
- ☐ Speech & hearing problems
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Mouth breathing due to nasal obstruction
- ☐ High or low blood pressure
- ☐ Anaemia, Leukaemia or other blood disorders
- ☐ Lung disease
- ☐ Autism / Asperger's Syndrome
- ☐ Contact with AIDS (HIV) virus
- ☐ Cerebral Palsy

Any other conditions which may affect ability to undertake orthodontic treatment (please list)

____

____

Has the patient

Had any significant health problems in the past? If yes please detail____

____

Any current health problems? If yes please detail____

____

Any behavioural concerns that may preclude orthodontic treatment? ☐ Yes ☐ No

Had an orthodontic consultation previously? ☐ Yes ☐ No

Had any orthodontic treatment previously? If yes, please give details____

____

Had an injury to the baby or permanent teeth? If yes, please give details____

____

Had an injury to the face, jaws or chin? If yes, please give details____

____

Has the patient ever

Sucked his/her thumb or finger, or similar habit? ☐ Yes ☐ No

Experienced clicking, popping or grating sound from the jaw joint? ☐ Yes ☐ No

Experienced pain from the jaw joints or facial muscles? ☐ Yes ☐ No

Name of person completing this form____

Relationship to patient____

Signature ____ **Date**____________________

Patient Name____ **D.O.B** ____________________

Patient ID No____

Information reviewed:

Any changes to be noted____

Patient signature/parent signature (if patient under 18 years of age)____________________Date____________________

Relationship to patient ____