straight orthodontics
health | harmony | confidence

ORTHODONTIC PATIENT INFORMATION

Welcome to Straight Orthodontics!

The following information is requested to help us better understand your orthodontic needs during your initial examination with us. Accurate background and health information assists us in providing the highest standard of care. This information is confidential.

Please circle/tick the appropriate response where indicated. Thank you.

PATIENT'S DETAILS

PATIENT'S NAME (TITLE / FIRST NAME / LAST NAME) | AGE | D.O.B | SEX M / F (PLEASE CIRCLE)

HOME ADDRESS (STREET / SUBURB / POSTCODE)

HOME PHONE | WORK PHONE | MOBILE

EMAIL

PATIENT'S OCCUPATION

SCHOOL PATIENT ATTENDS (if applicable) | GRADE/ YEAR

EMERGENCY CONTACT | PHONE

MEDICAL DOCTOR (NAME / ADDRESS) | PHONE

FAMILY DENTIST (NAME / ADDRESS) | PHONE

WHO RECOMMENDED YOU TO US? | PHONE

ACCOUNT PAYER'S DETAILS

PERSON RESPONSIBLE FOR FEES | RELATIONSHIP TO PATIENT

HOME ADDRESS: (STREET / SUBURB / POSTCODE)

HOME PHONE | WORK PHONE | MOBILE

MEDICAL AND DENTAL HISTORY (PLEASE CIRCLE)

GENERAL HEALTH: **GOOD** **FAIR** **POOR**

DO YOU HAVE ANY:

MEDICAL CONDITIONS? **YES** **NO**

ALLERGIES? **YES** **NO**

If yes to either, please specify _____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

ARE YOU CURRENTLY:

UNDER ANY MEDICAL TREATMENT? (INCLUDING HOMEOPATHIC/NATURAL THERAPIES) **YES** **NO**

TAKING ANY MEDICATION? **YES** **NO**

If yes, please specify:_____

DO YOU SMOKE? **YES** **NO** IF YES, HOW MANY PER DAY:_____

DOES THE PATIENT HAVE / HAS THE PATIENT EVER HAD: (please tick)

AIDS / HIV	FAINTING	HYPERTENSION
ASTHMA	GUM DISORDERS	MOUTH LESIONS
ANAEMIA	HEART DISEASE	RHEUMATIC FEVER
BLEEDING DISORDER	HEARING DISORDER	TUBERCULOSIS
BONE DISORDER	THYROID PROBLEMS	HERPES
DIABETES	HEPATITIS	EPILEPSY

IF YES TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS: _____

_____

DOES THE PATIENT:

1. ALWAYS OR MOSTLY BREATHE THROUGH THEIR MOUTH? **YES** **NO**
2. SNORE WHEN SLEEPING? **YES** **NO**
3. HAVE DIFFICULTY CHEWING OR SWALLOWING? **YES** **NO**
4. HAVE PAIN OR CLICKING IN THE JAW JOINT? **YES** **NO**

HAS THE PATIENT:

1. HAD TONSILS REMOVED? **YES** **NO**
2. HAD ADENOIDS REMOVED? **YES** **NO**
3. HAD ANY TRAUMA TO THE MOUTH, CHIN OR JAW? **YES** **NO**
4. RECEIVED OR BEEN RECOMMENDED SPEECH CORRECTION? **YES** **NO**

OTHER CONDITIONS OF INTEREST:

THUMB/FINGER SUCKING? **YES** **NO** PAST OR PRESENT _____ UNTIL WHAT AGE? _____

TEETH GRINDING? **YES** **NO**

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT? **YES** **NO**

YEAR: _____DR:_____

HAS ANY MEMBER OF YOUR FAMILY HAD ORTHODONTIC TREATMENT? **YES** **NO**

IF THERE ARE ANY OTHER MEDICAL, DENTAL OR SURGICAL PROBLEMS NOT COVERED ABOVE, PLEASE DESCRIBE:_____

_____

PATIENT'S DENTAL HEALTH AND AWARENESS

DENTAL CHECK-UPS: **Annual** **Every 6 months** **Only for Emergencies** **Never**

APPROXIMATE DATE OF LAST DENTAL CHECK-UP: _____

IS THE PATIENT AWARE OF ANY ORTHODONTIC PROBLEM? **YES** **NO**

SIGNED:_____

PRINT NAME:_____ **DATE:**_____

THANKYOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS FULLY AS POSSIBLE.

PLEASE COMPLETE BOTH SIDES OF THIS FORM