angle ORTHODONTICS house

7 Whitehorse Rd, Balwyn. Ph 9817 6427

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Patient Information (please print)

Dr / Mr / Mrs / Ms / Miss / Master / Other

Surname……

Given Name (as per passport/Medicare card) …….

Preferred Name……

Address……..

……Postcode…….

Mobile Number: Patient:……..Mum/Dad:…….

Emergency Contact (name and number): ……

Email Address……

DOB:…….School/Occupation……

Gender Identification: (please circle): Male / Female / Non Binary

Regular Dentist Name: Dr…… Phone: ……

Dentist Email: ……..Suburb…….

Private Health Fund……

Medicare Number: …… Position on Card ……..

Medicare Number Expiry date: ……

How did you hear about our practice? (Please circle)

Dentist / Website / Friend / Family / Signage / Social Media /Other

Have any other family members attended these rooms, if so name:

……

What concerns you most about your teeth?……

Billing Information (please print)

(If Child) Mother's full name……..Father's full name……

Name and address of person responsible for account……

……

Correspondence addressed to:

……

Please turn over……

Medical Information:

Have you ever had any of the following? Please indicate

	YES	NO		YES	NO
Diabetes	☐	☐	Rheumatic Fever	☐	☐
High/Low Blood Pressure	☐	☐	Asthma/Breathing Problems	☐	☐
Heart Ailment	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Thyroid Problems	☐	☐
Stomach/Bowel Problems	☐	☐	Hepatitis	☐	☐
Kidney Disease	☐	☐	HIV/AIDS	☐	☐
Excessive Bleeding	☐	☐	Learning Difficulties	☐	☐
Are you a smoker ?				☐	☐
Do you have an artificial hip, heart valve or other prosthetic implant?				☐	☐
Are you presently under medical care?				☐	☐

Please explain……..

Are you presently taking any medication? ☐ ☐

Please list:…….

Do you have any known allergies? ☐ ☐

Please list:…….

List any other previous illnesses:……..

Have you ever had problems with dental treatment?……

Female patients, are you pregnant? ☐ ☐

Would you like to discuss these questions in private with your Orthodontist? ☐ ☐

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS THOROUGHLY AS POSSIBLE

 # I have completed this Questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue risk. I understand that notes, radiographs (xrays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send appointment and check up reminders.

 # I give my consent for xrays,models and photographs to be used for marketing, research and continuing education purposes…… YES / NO

 # I am happy for Angle House to contact me via email with regard to practice news and other initiatives……YES / NO

Patient Name: ……

Parent/Guardian Signature……**Date**……

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED