angle ORTHODONTICS house

7 Whitehorse Rd, Balwyn. Ph 9817 6427

PLEASE COMPLETE BOTH SIDES AND BRING TO APPOINTMENT

Patient Information

Mr/Mrs/Ms/Miss/Mst

Surname…….

Given Name……Preferred Name…….

Address……

…… Postcode……

Phone Number (Home)…… (Work) ……Mum/Dad

Mobile:(Patient):……..(Mum/Dad):…….

Emergency Contact……..

Email Address……

DOB:……..School/Occupation……

Dentist……Suburb……..

Health Fund……

How did you hear about Our Practice?……Please circle below

Newspaper / Dentist / WebSite / Friend / Family / Yellow Pages / Other

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

…….

Mothers Full name……..…Fathers Full name……..……

Name and address of person responsible for account…….

……

Correspondence addressed to:

……

What concerns you most about your teeth?……

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

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	☐	☐

Do you Smoke or have you ever been 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:……

List any previous Hospitalisations:……

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 me appointment reminders.

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

Patient Name:……

Parent/Guardian Signature…….**Date**……..

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED