

orthodontics

e x c l u s i v e l y

Sydney's Premier Orthodontic Partnership

PATIENT CONSULTATION QUESTIONNAIRE

Please note, the consultation fee will range between \$155.00 - \$495.00, depending on records taken.
This fee is payable on the day by EFTPOS, credit card, cheque or cash.

All information contained herein will be kept completely confidential.

PLEASE PRINT

PATIENT DETAILS

Title Surname First Name Middle Name Date of Birth

Home Address: Postcode:

Postal Address: Postcode:

Home: Mother Father Work: Mother Father Fax:

Mobile: Mother Father SMS Email: Tick for

Mobile number for SMS appointment reminders, if different to above:

Preferred phone number to call during business hours: HOME WORK MOBILE

Patient responsible for own fees: YES NO

If YES please sign Signature if NO Account Details (p3) must also be completed

Name of School or Occupation:

Who referred you to our practice?

Has a previous orthodontic consultation been sought? YES Tick for

Details:

Names of other members of the family treated by our practice:

HEALTH FUND? YES Tick for Name:

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DENTAL HISTORY

Name of Dentist:

Have orthodontic appliances been worn previously? Tick for YES Details:

DENTAL TRAUMA

Have any accidents been suffered causing:

- | | | | |
|--------------------------------|--------------------------|------------------------------|--------------------------|
| 1. Tooth displacement or loss | <input type="checkbox"/> | 4. Disturbance to jaw joints | <input type="checkbox"/> |
| 2. Chipping of the front teeth | <input type="checkbox"/> | 5. Facial fractures | <input type="checkbox"/> |
| 3. Discolouration of teeth | <input type="checkbox"/> | | |

ORTHODONTIC CONCERNS

- | | | | |
|--------------------------------------|--------------------------|-------------------------------------|--------------------------|
| 1. The appearance of irregular teeth | <input type="checkbox"/> | 6. Grinding/Clenching | <input type="checkbox"/> |
| 2. The inability to chew effectively | <input type="checkbox"/> | 7. Clicking sounds from joints | <input type="checkbox"/> |
| 3. A speech defect | <input type="checkbox"/> | 8. Pain in the face or jaw joints | <input type="checkbox"/> |
| 4. Thumb or finger sucking habit | <input type="checkbox"/> | 9. The concern of referring dentist | <input type="checkbox"/> |
| 5. Missing teeth | <input type="checkbox"/> | 10. Facial appearance | <input type="checkbox"/> |

Is patient prepared to wear fixed appliances (braces) if necessary? 'Tick for YES

MEDICAL HISTORY

Name and telephone number of Medical Practitioner:

Does patient take medication? Tick for YES Please list:

Does the patient have any allergies? Tick for YES Please specify:

Females : Tick for
Are you pregnant? YES

HEALTH WARNINGS

Have any medical problems been experienced in the following areas:

- | | | |
|------------------------------|--------------------------|-----------------------------------|
| Rheumatic fever/Heart murmur | | Asthma/Hay fever |
| Heart valve | <input type="checkbox"/> | Lung disorder |
| Heart damage | | Kidney/Liver disorder |
| Heart attack/Angina | <input type="checkbox"/> | Physical/Psychological disability |
| Heart surgery/Pacemaker | | Radiotherapy/Chemotherapy |
| High blood pressure | | Speech, hearing or sight problems |
| Stroke | | Cleft lip or palate |
| Epilepsy | | Excessive bleeding |
| Thyroid | | Hepatitis B or C |
| Diabetes | | HIV/AIDS |
| Tuberculosis | | Arthritis |

Details:

ACCOUNT DETAILS

(Fill out this section if patient not responsible for fees)

If two or more parties wish to share payment of the Consultation fee, please advise details to our practice in advance. Fees cannot be charged to another party without their written consent. 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

Address for Accounts:

Postcode:

Telephone (home):

(mobile):

Employer/Business Name:

Employer/Business Address:

Postcode:

Telephone:

Signature of person responsible for fees: _____

THIS SECTION TO BE COMPLETED IF PATIENT IS UNDER THE AGE OF EIGHTEEN YEARS

Parent/Guardian:

Title

Surname

First Name

Relationship to patient

Parent/Guardian:

Title

Surname

First Name

Relationship to patient

Patient resides with: BOTH PARENTS MOTHER FATHER OTHER :

GROWTH AND DEVELOPMENT

Has there been any recent rapid growth? YES NO How much?

Father's height?

Mother's height?

Have any facial or dental characteristics been inherited?

Females:

Has menstruation begun?

Tick for

YES

If yes, when?

END OF UNDER AGE SECTION

PLEASE SIGN AND DATE TO CONFIRM ALL DETAILS PROVIDED ARE TRUE AND CORRECT

SIGNATURE :

DATE :

ORTHODONTIST'S SIGNATURE: _____