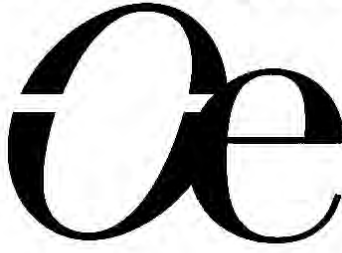


o r t h o d o n t i c s



e x c l u s i v e l y

## PATIENT CONSULTATION QUESTIONNAIRE

**Please note**, the consultation fee will range between \$160.00 - \$510.00, depending on records taken.

**This fee is payable on the day by EFTPOS, credit card, cheque or cash**

**Please note that if the appointment is cancelled with less than 48 hours notice, a 50% cancellation fee may apply.**

**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

Do you wish to receive reports by Email? : YES NO

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 NO Tick for

Details:

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

HEALTH FUND? YES NO Name: Tick for

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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 : Are you pregnant? Tick for 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:**

\_\_\_\_\_