# NEW PATIENT
# MEDICAL & DENTAL HISTORY FORM

*Please note that all information on this form will remain strictly confidential.*

Title: *(please circle)* *Dr / Mr / Mrs / Ms / Miss / Master / Other* Gender: *(please circle)* *Male / Female / Other*

Name: *First* *Last* *Preferred*

Date of Birth: Age:

Address:
*Street* *City/Suburb* *State* *Post Code*
*PO Box* *City/Suburb* *State* *Post Code*

Phone: *Home* *Mobile* *Work*

Email:

Emergency Contact: *Name* *Phone* *Relationship*

Occupation: Workplace:

Health Insurance: *(please circle)* *Private Health Insurance / Public Heath Care Card / None*

*Private Health Fund Name (if applicable)* *Orthodontic Cover: (please circle) Y / N / Unsure*

How did you hear about us? *(please circle all that apply)*
*Website or Google / Social Media / Friend or Family / Bus or Advertising / Word of Mouth / Other:*

Cultural History: *(please circle)* *Australian Citizen / Resident / Visitor / Other*

*Do you come from a different cultural, linguistic, religious or other background you would like us to know about? (please circle) Y / N*

*If yes, please provide more information here -*

## UNDER 18 – *If the patient is under 18 years of age, please complete the following. – Over 18, please go to next section.*

If you are completing this form for another person, what is your relationship to the patient?
*Name* *Relationship*

Patient lives with: *(please circle)* *Both Parents / Mother / Father / Guardian / Grandparent/s / Other:*

Are there any shared custody arrangements or court orders? *(please circle) Y / N*
*If yes, please provide more information here –*

Do you require 2 copies of any treatment plans or any other information provided? *(please circle) Y / N*
*If yes: Name* *Email*

Has there been any recent family stress or social changes? *(please circle) Y / N*
*If yes, please provide more information here –*

School: *Name of School* *Year Level*

Family History:
*Responsible Party 1: Name* *Date of Birth* *Occupation*

*Responsible Party 2: Name* *Date of Birth* *Occupation*

*Siblings:*

| *Name* | *Age* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

*Some dental conditions can run in families, this means there may be another sibling with similar discrepancies that may require assessment also.*

***- please continue to next page -***

## DENTAL HISTORY

General Dentist: *Name* *Practice*

*When was your last dental check?*

*Is there any outstanding work to be done? Eg. fillings, clean etc*

Have you had an orthodontic x-rays taken in the last 12 months? *Eg. OPG and/or Lateral Ceph (please circle) Y / N / Unsure*

On a scale of 1-5, how do you feel about dental treatment? *(please circle)*

*Totally relaxed* | 1 2 3 4 5 | *Utterly terrified*

Are you experiencing any pain or discomfort in your head/neck/teeth? *(please circle) Y / N*

*If yes, please provide more information here –*

How many times a day (24 hour period) do you brush your teeth? *(please circle) Twice / Once / Other:*

What is the main reason/concern for seeking orthodontic treatment?

Is there any other information you would like to let us know about your teeth?

## MEDICAL HISTORY

Doctor: *Name* *Practice*

Has the patient ever had any of the following? *– Please tick all that apply and provide any further information below.*

- O ADD/ADHD
- O Anaemia
- O Arthritis
- O Artificial Heart Valve
- O Artificial Joints (Hip, Knee etc.)
- O Asperger's/Autism Spectrum
- O Asthma/Sinus Problems
- O Behavioural Disorders
- O Blood Disorder
- O Blood Pressure (High / Low)
- O Cancer/Tumour
- O Diabetes
- O Dizziness/Fainting
- O Epilepsy
- O Excessive Bleeding
- O Glaucoma
- O Heart Disease
- O Heart Murmur
- O Hepatitis (A, B, or C)
- O HIV/AIDS
- O Kidney Disease
- O Liver Disease
- O Osteoporosis
- O Pacemaker
- O Psychiatric Disorders
- O Radiation Therapy
- O Respiratory Problems
- O Rheumatic Fever
- O Stroke/Heart Attack
- O Transplanted Organ
- O Tuberculosis
- O Other *(please list below)*
- O **NONE OF THE ABOVE**

*Please provide any further information here:*

_____

_____

_____

Have you had any serious illness in the last 2 years? *(please circle) Y / N*

*If yes, please provide more information here –*

Are you currently taking any regular medications? *(please circle) Y / N*

*If yes, please provide more information here –*

Are you taking or have taken any Bisphosphonate drugs? e*g Fosamax. (please circle) Y / N*

Do you have any allergies? e*g Penicillin, Latex, Environmental etc (please circle) Y / N*

*If yes, please provide more information here –*

Do you smoke? *(please circle) Yes / No / Not Applicable*

Are you pregnant*? (please circle) Yes / No / Unsure* *If yes, number of weeks:*

***- please continue to 'Consent for Services, Consumer Rights & Privacy Policy' -***

# CONSENT FOR SERVICES, CONSUMER RIGHTS & PRIVACY POLICY

In order to provide you with the highest standard of care, this practice is required to collect personal information from you. The information covers basic details such as your name, address and telephone number but it is also necessary for the orthodontist to obtain from you details regarding your general health and past medical, dental or surgical events. Without this general health picture, the treating orthodontist is unable to plan your care properly.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating orthodontist in order to deliver your care to the highest standards.
- It will not be disclosed to those not associated with your treatment, without your express consent.
- You may seek access to the information held about you and we will provide this access without undue delay. This access might be by the inspection of your orthodontic records at the time of appointment or by special access or copying of information at other times.
- There will be no charge made for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request or the copying of information.
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up to date.
- Our staff are trained to respect these principles at all times.

Everyone who is seeking or receiving care in the Australian heath system has certain rights regarding the nature of that care. These are described in the Australian Charter of Healthcare Rights.

These rights are:

- **ACCESS** – A right to heath care.
- **SAFETY** – A right to safe and high quality care.
- **RESPECT** – A right to be shown respect, dignity and consideration.
- **COMMUNICATION** – A right to be informed about services, treatment, options and costs in a clear and open way.
- **PARTICIPATION** – A right to be included in decisions and choices about care.
- **PRIVACY** – A right to privacy and confidentiality of provided information.
- **COMMENT** – A right to comment on care and having concerns addressed.

*For more information on the charter visit www.safetyandquality.gov.au*

*I, _____, have completed the Medical & Dental History Form to the best of my knowledge, have read and understood the 'Consent for Services, Consumer Rights & Privacy Policy' and I am aware of any legislation involved. I am aware that it is my responsibility to inform the doctor or other health care professional of my current medical or health conditions and to update this history when necessary and therefore consent to any services required by NQ Ortho.*

***Signature** (of person completing this form)**:** _____ **Date:** _____*

***- Thank You for completing the form, please return to reception -***