ADULT PATIENT INFORMATION & MEDICAL HISTORY FORM

Title:_____ Patient's Surname _____ First Name_____ Middle Initial_____

Gender: ❑ Male ❑ Female Date of Birth ___/___ / ___ Age: _____

Home Address _____Post Code_____

Telephone: Home_____ Work_____ Mobile_____

E-mail_____

Patient's Occupation _____Work Address _____Post Code_____

Other family members in the practice_____

Patient's Dentist name & address _____

Has the patient had a check up and/or clean recently? YES/NO Patient's Doctor _____

Does the patient have Dental Insurance for Orthodontics? YES / NO Which Fund? _____

Who can we thank for referring you?

Dental Practitioner

❑ Dentist
❑ Dental therapist/hygienist
❑ Oral Surgeon
❑ Periodontist
❑ Prosthodontist
❑ Paedodontist

Please name Doctor:

_____

Other_____

Internet

❑ Our website
❑ Facebook
❑ Internet **Please circle**
Google / Bing / Yahoo

Other_____

❑ Invisalign website
❑ The Invisible Orthodontist
❑ Blog

Word of mouth

❑ Patient - Friend
Name_____

❑ Patient - Family member
Name_____

❑ Parent of patient
Name_____

❑ Word of mouth

_____

Advertisement

❑ School program/advertisement
Specify_____

❑ Signage
Specify_____

❑ Sponsorship
Specify_____

❑ Newspaper
❑ Bus shelter ad
Other_____

PERSON RESPONSIBLE FOR FEES: ❑ Self / ❑ Other – Relationship to Patient _____

Contact details **if not self**: Name (include title) _____

Address _____

Mobile Phone_____ Home Phone_____ Work Phone_____

PATIENT'S DENTAL HISTORY: Have any teeth been extracted? YES/NO/UNSURE Any missing permanent teeth? YES/NO/UNSURE

History of trauma to teeth, mouth or face _____

Past or present habits (e.g. thumb/finger sucking, tongue thrusting, lip biting, etc.)_____

Past orthodontic consultation YES/NO Past orthodontic treatment (e.g. plates/braces)_____

Other significant dental history (e.g. missing teeth, root canal, TMJ) _____

Main concerns about patient's teeth? _____

PATIENT'S MEDICAL HISTORY: (Please tick where applicable)

❑ Asthma ❑ Birth defects ❑ Bleeding disorders ❑ Bone disorders
❑ Diabetes ❑ Anxiety ❑ Epilepsy ❑ Growth problems
❑ Heart murmur ❑ Heart disease ❑ Hepatitis ❑ High blood pressure
❑ Headaches/Migraines ❑ HIV / AIDS ❑ Kidney disease ❑ Allergies_____
❑ Other_____
❑ Current Medication _____

Should you have any medical condition which may require further discussion, please advise

Please turn over

To the best of my knowledge, the information on the previous page is complete and correct.

Patient Signature _____ Name _____ Date _____

PRIVACY POLICY

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988, we consider the protection of your privacy and personal information to be a high priority. Therefore, we realise that it is important that you are aware of why we collect, how we use and to whom we may disclose your information.

The policy of our practice is to follow these procedures:

- The information collected will be used for the purposes of providing treatment to you. Personal information such as your name address and other details will be used for the purpose of accounts and payments and writing to you about your treatment and our services.
- We may disclose your health information to other health care professionals or require it from them if necessary for your treatment. In that event, disclosure of your personal details will be minimised.
- We may also use parts of your health information for research purposes in study groups or at seminars and lectures as this may be of benefit to other patients. Your personal identity will not be disclosed.
- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

We respect your privacy and this information will be held in the strictest confidence.

Please sign here as confirmation that you understand and consent to our privacy policy.

Patient Signature _____ Name _____ Date _____

AUTHORITY TO REQUEST/REFER RECORDS TO HEALTH CARE PROVIDERS

We may need to request records from your previous or current dentist or specialist to assist with your orthodontic treatment planning. We also correspond with and forward x-rays to your dentist or other specialists for treatment planning when required. During your treatment, we may need to refer you to other specialists. To ensure compliance with Federal and State Privacy Legislation we require your signed consent to work with other health care professionals.

Patient Signature _____ Name _____ Date _____
