

CHILD 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 School/University/Occupation: _____

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 | Internet | Word of mouth | Advertisement |
|---|--|--|---|
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Our website | <input type="checkbox"/> Patient - Friend | <input type="checkbox"/> School program/advertisement |
| <input type="checkbox"/> Dental therapist/hygienist | <input type="checkbox"/> Facebook | Name _____ | Specify _____ |
| <input type="checkbox"/> Oral Surgeon | <input type="checkbox"/> Internet <small>Please circle</small> | <input type="checkbox"/> Patient - Family member | <input type="checkbox"/> Signage |
| <input type="checkbox"/> Periodontist | Google / Bing / Yahoo | Name _____ | Specify _____ |
| <input type="checkbox"/> Prosthodontist | Other _____ | <input type="checkbox"/> Parent of patient | <input type="checkbox"/> Sponsorship |
| <input type="checkbox"/> Paedodontist | <input type="checkbox"/> Invisalign website | Name _____ | Specify _____ |
| Please name Doctor: _____ | <input type="checkbox"/> The Invisible Orthodontist | <input type="checkbox"/> Word of mouth | <input type="checkbox"/> Newspaper |
| Other _____ | <input type="checkbox"/> Blog | _____ | <input type="checkbox"/> Bus shelter ad |
| | | | Other _____ |

PARENT DETAILS

Correspondence to be sent to: Father Mother Both

Father: Title: _____ Name: _____
Address (As above/Other) _____ Post code: _____
Home phone (As above/Other) _____ Work phone: _____
Mobile: _____ Email: _____

Mother: Title: _____ Name: _____
Address (As above/Other) _____ Post code: _____
Home phone (As above/Other) _____ Work phone: _____
Mobile: _____ Email: _____

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)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Bone disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Growth problems |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Current Medication _____ | | | |

If you wish to discuss any medical aspects in private (ie: without the patient), please tick box:

To assist with assessing growth, has the patient reached puberty?

Girls- Has menstruation started? Yes No

Boys- Has voice changed? Yes No

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

Parent 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.

Parent 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.

Parent Signature _____ Name _____ Date _____
