Australian Society of Orthodontists

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SPECIALIST ORTHODONTIST

In order to provide the highest standard of orthodontic care, It is requested that you fill in this form carefully

TODAY'S DATE: ...../...../.....

PATIENT NAME:... **PATIENT EMAIL**...

PREFERRED TITLE: (PLEASE CIRCLE) MISS MRS MS MASTER MR DR PROF OTHER ....

BIRTHDATE: ...../...../..... AGE: ....(YEARS) **SEX** ☐ MALE ☐ FEMALE **SCHOOL:** .... **GRADE**: ....

HOME ADDRESS: ....SUBURB: .... POSTCODE:........

POSTAL ADDRESS:(IF DIFFERENT TO HOME) ....SUBURB: .... POSTCODE:........

HOME PHONE: ....**PATIENT MOBILE PHONE**..

BUSINESS PHONE: ....**FAX NUMBER**..

FATHER'S NAME...
Father's Preferred Title ....
Home Address (If Different to Above)
Street ....
Suburb ....
Home Phone..................................Mobile ....
Bus Phone ....Fax ....
Email...
Preferred Contact Email Fax Letter

MOTHER'S NAME……………………………………………………
Mother's Preferred Title ....
Home Address (If Different to Above)
Street ....
Suburb ....
Home Phone.................................Mobile ....
Bus Phone ....Fax...............................
Email...
Preferred Contact Email Fax Letter

PERSON(S) RESPONSIBLE FOR ACCOUNT: ☐ Father ☐ Mother ☐ Self ☐ Spouse ☐ Other ....

Name ....
Employed by .... Occupation ....
Business address .... City ....
Business Phone ....Mobile phone... Fax ....

Would you like **EMAIL** confirmation to remind you of appointments? ☐ Yes ☐ No
Medicare Number: ……/……/……/……/ ……/……/……/……/……/…….. .... Patient Ref number: ………..

NAMES AND AGES OF OTHER CHILDREN IN FAMILY Name Date of Birth

....
....
....
....

General Dentist .... Address .... Phone ....

Medical Practitioner .... Address .... Phone ....

In case of emergency, name of nearest relative not living at your address..
Address .... Phone ....

Reason for Seeking Orthodontic Treatment ....

....

....

What person (other than your dentist) suggested that you visit us?...

Privacy is very important. Your information is confidential. Please ask to see our Privacy Policy for further information. Thankyou for taking the time to answer so many questions. While some of the questions may not seem relevant, they all are very important in the development of an orthodontic treatment plan. My staff are happy to explain the rationale for these questions and any queries that may arise from them.

Please turn the page and complete the medical, dental and growth information.

DENTAL AND MEDICAL HISTORY FORM

Current and Past Medical History (Please Circle)

Presently under physicians care? ....No ....Yes
Taking Medication? ....No ....Yes
Please List... ....
....
High Blood Pressure? ....No ....Yes
Heart Problems? ....No ....Yes
Rheumatic Fever? ....No ....Yes
Antibiotics required before treatment?.................No ....Yes
Asthma?...No ....Yes
Chest or breathing problems? ....No ....Yes
Tuberculosis? ....No ....Yes
Stomach or bowel problems (eg ulcer)? ....No ....Yes
Kidney Disease ....No ....Yes
Diabetes? ....No ....Yes
Thyroid problems? ....No ....Yes
Blood disorder or excessive bleeding ....No..................Yes
Epilepsy or convulsions? ....No ....Yes
Hepatitis or liver problems? ....No ....Yes
Artificial hip/heart valve/other implant ....No ....Yes
Unusual childhood diseases? ....No ....Yes
Dizziness or fainting? ....No ....Yes
Birth defects? ....No ....Yes
AIDS/HIV? ....No ....Yes
Poor speech ....No ....Yes
Poor hearing? ....No ....Yes
Do you have allergies ....No..................Yes
Female patients, Are you pregnant? ....No ....Yes

Please briefly explain any **Yes** answers
....
....
....
Please list any medicines or products you are allergic to.................
....
....

Current and Past Dental History (Please Circle)

Has the patient worn orthodontic plates? .... No ....Yes
When? ....
Has the patient worn braces or retainers? .... No ....Yes
When? ....
Has the patient seen another orthodontist? .... No ....Yes
Has anyone in the family worn braces? .... No ....Yes
Does the patient's mouth resemble another family member?... No ....Yes

Whom? ....

Have any teeth been extracted? .... No ....Yes
Has there been any injuries to the teeth or jaws? ... No ....Yes
Does the patient have any gum disease? .... No ....Yes
Do the patient's gums bleed during brushing? .... No ....Yes
Are you unhappy with your present dental care? .... No ....Yes

The patient brushes: Once /day.....Twice /day .... Other
The patient uses dental floss Never............Occasionally .... Daily
Co operation at the dentist is Poor.............Fair ....Excellent

Do Any Of The Following Habits Exist?

Thumb or Finger Sucking .... No ....Yes
When did it stop? ....
Grinding Teeth .... No ....Yes
Clenching Teeth .... No ....Yes
Fingernail Biting .... No ....Yes
Lip Sucking .... No ....Yes
Lip Biting .... No ....Yes
Tongue Thrusting .... No ....Yes
Abnormal Swallowing .... No ....Yes
Mouth Breathing .... No ....Yes
Please briefly explain any **Yes** answers
....
....
....

Jaw Joint Screening History (Please Circle)

Do you have difficulty or pain (or both) when opening your mouth, for example when yawning? . No ....Yes
Does your jaw get stuck, locked or go out? .... No ....Yes
Do you have difficulty or pain (or both) when chewing, talking or using your jaw? .... No ....Yes
Are you aware of noises in the jaw joint? .... No ....Yes
Do you have any pain in or about the ears, temples or cheeks? .... No ....Yes
Do you have frequent headaches? .... No ....Yes
Have you had any recent injury to your neck, head or jaws? .... No ....Yes
Have you previously been treated for a jaw joint problem? .... No ....Yes If yes, when?……........

Growth Status. If the patient is 15 years old or younger please answer the following (Please Circle)

This section is important to understand the growth status of the patient. Remaining growth can determine orthodontic options available.

Patient's Height (Feet /inches or cm)......................................
Parent's **Estimate** of fully-grown height (Feet /inches or cm) ....
Father's Height (Feet /inches or cm) ....
Mother's Height (Feet/inches or cm) ....
Growth and development...Slow................Normal............Advanced..............Weight ....kg
For **Girls** Has menstruation started ....No...................Yes ....Month....................Year................
For **Boys** Has voice changed ....No...................Yes ....Month....................Year................
How do you think the patient will react to orthodontic treatment? .....Poor................Normal............Excellent ....

I have completed the questionnaire to the best of my knowledge and understand that failure to make a disclosure may place me at undue medical risk. I understand that notes, radiographs (x-rays), photographs or models relating to my treatment may need to be sent to other dental or health practitioners to aid them in my treatment and I consent to this. I give my permission for the practice to use the contact details to send me appointment and check-up reminders.

Signature of patient (if patient is over 18 years of age)

X..............................

Date: …../……../…..

Signature of Parent (if patient is under 18 years of age)

X ....

Date: …../……./……