VIRTUOSUM ORTHODONTICS

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Patient Information & Medical History Form

Patient Details

Title ____ First Name _____ Middle Initial ___ Surname _____

Date of Birth __/__/__ Age ___ ☐ MALE ☐ FEMALE

School _____ Grade _____

Home Address _____ Postcode _____

Patient Email _____Patient Mobile _____

Reason For Seeking Orthodontic Treatment_____

_____

Person responsible for account ☐ SELF ☐ MOTHER ☐ FATHER ☐ OTHER _____

Patient's Dentist Name & Address_____

Patient's Doctor's Name & Address_____

Mother's Details

Title ____ First Name _____ Middle Initial ___ Surname _____

Home Address (if different)_____ Postcode _____

Mother's Email _____ Mother's Phone _____

Father's Details

Title ____ First Name _____ Middle Initial ___ Surname _____

Home Address (if different)_____Postcode _____

Father's Email _____ Father's Phone _____

Patient Sibling Details

Name _____Age _____Name _____Age_____

Name _____Age _____Name _____Age_____

Patient Dental History

Have any teeth been extracted? ☐ YES ☐ NO Any MissingPermanent Teeth? ☐ YES ☐ NO

History of Trauma to the Teeth/Jaws/Mouth/Face ☐ YES ☐ NO_____

Thumb or Finger Sucking? ☐ YES ☐ NO Tongue Thrusting? ☐ YES ☐ NO Lip Sucking? ☐ YES ☐ NO

Previous Orthodontic Consultation? ☐ YES ☐ NO Previous Orthodontic Treatment? ☐ YES ☐ NO

Patient Growth Status (This Can Determine Orthodontic Treatment Options)

Patient's Height (cm) _____ Father's Height (cm) _____ Mother's Height(cm) _____

Has the Patient Reached Puberty? ☐ YES ☐ NO

For Girls-Has Menstruation Started? ☐ YES ☐ NO

For Boys-Has Voice Changed? ☐ YES ☐ NO

PATIENT MEDICAL HISTORY (PLEASE TICK)

□ Asthma □ Diabetes □ Heart Problems □ Antibiotics Required Before Treatment

□ Heart Disease □ Headaches/Migraines □ HIV/AIDS □ Hepatitis □ Epilepsy □ Allergies

□ Excessive Bleeding □ Kidney Disease □ Growth Problems □ Bone Disorders □ Blood Pressure

□ Current Medication_____

□ Other_____

Please Explain Any Ticked Boxes_____

_____

THE INFORMATION THAT I HAVE COMPLETED IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Parent Signature _____**Parent Name** _____**Date**_____

WHO CAN WE THANK FOR REFERRING YOU?

□ My Dentist □ Dental Therapist/Hygienist □ Other Specialist_____

□ Our Website □ Facebook □ Internet □ Invisalign □ Staff Member_____

Friends Name_____ □ Family Member Name_____

□ Parent of Patient Name_____ □ Word of Mouth_____

□ Practice Sign □ Sponsorship (Specify_____ □ Other_____

PRIVACY POLICY

Virtuosum Orthodontics respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles (APPs).

We collect information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your health care. We may collect information about you from third parties providing the collection of that information is necessary to provide you with health care.

We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your care.

We may also use parts of your health information for research purposes, in study groups or at seminars; As part of its electronic records system, the practice may rely on cloud storage providers located outside Australia. The practice will ensure that any offshore transfer complies with its obligations under the APPs.

Please sign this form as confirmation that you have read and understood the above information and consent to the collection and use of your health information.

Parent Signature_____**Name**_____**Date**_____

AUTHORITY TO REQUEST/REFER RECORDS TO HEALTH CARE PROFESSIONALS

Virtuosum Orthodontics may need to request or provide records from or to your previous or current Dentist or Specialist to assist with your Orthodontic treatment planning. Such records may include, but not be limited to medical cares and treatment, illness or injury, dental and orthodontic history, medical history, consultation, prescriptions, X-rays and models.

Parent Signature_____**Name**_____**Date**_____