YOU AND YOUR FAMILY — ADULT

PATIENT'S DETAILS

Name: _____ Title: Ms / Miss / Mrs / Mr / Dr / Other _____.

Address: _____ Post code: _____.

Date of birth: _____ Email address: _____.

Phone (M): _____ (H) _____ (W) _____.

University/ Occupation: _____ Business address: _____.

_____ Post code: _____ Hobbies and interests: _____.

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient: _____.

Address: (As above/other) _____ Post code: _____.

Phone: (H) _____ (W) _____ (M) _____.

PERSON RESPONSIBLE FOR FEES

Name: _____.

Address: (Complete only if different to above) _____ Post code: _____.

Phone: (H) _____ (W) _____ (M) _____.

Email address: _____.

Do you have dental insurance for orthodontics? Yes / No If yes, which fund? _____.

Medicare number: _____ Individual reference number: _____

HOW DID YOU FIND OUT ABOUT US?

Family dentist/ Dental hygienist/ Relative/ Friend/ Our website/ Facebook/ Instagram/ Google/ Other _____.

YOUR DENTAL HEALTH

What is your dentist's name and address? _____.

_____ Post code: _____ Phone: _____ When was your last dental examination? _____.

Have you had any injuries to your face, teeth or mouth?	**Yes / No**
Are any of your teeth sore or uncomfortable?	**Yes / No**
Have you ever sucked a thumb or fingers?	**Yes / No**
Do you have any jaw problems (e.g. clicking or locking)?	**Yes / No**
Have you ever had any serious problems with dental treatment?	**Yes / No**
Is there a family history of orthodontic problems/treatment?	**Yes / No**
Have you had any previous orthodontic treatment?	**Yes / No**

YOUR ORTHODONTIC CONCERNS

What is your main concern regarding your teeth and/or bite? .

Do you have any aesthetic concerns? .

Do you have any functional concerns? .

Do you have a preference for the method used to straighten the teeth? Clear aligners / Ceramic braces / Metal braces / No preference

YOUR GENERAL HEALTH

What is your doctor's name and address? .

Post code Phone: .

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Asthma or breathing problems	**Yes / No**	**Stomach or bowel problems**	**Yes / No**
High blood pressure	**Yes / No**	**Kidney disease**	**Yes / No**
Heart problems	**Yes / No**	**Diabetes**	**Yes / No**
Rheumatic fever	**Yes / No**	**Thyroid problems**	**Yes / No**
Autism spectrum disorder	**Yes / No**	**Excessive bleeding or blood disorder**	**Yes / No**
ADHD or behavioral issues	**Yes / No**	**Epilepsy**	**Yes / No**
Anxiety	**Yes / No**	**Hepatitis**	**Yes / No**
Depression	**Yes / No**	**HIV/AIDS**	**Yes / No**
Tuberculosis	**Yes / No**	**Joint problems or arthritis**	**Yes / No**

List any other current or previous illnesses .

List any tablets or medicines currently being taken

Have you ever stayed in hospital, had an operation, or a general anaesthetic? Yes / No

If yes, please provide details

Do you have an artificial hip, heart valve or other prosthetic implant? Yes / No

Are you allergic to any medicines or products (e.g. penicillin, latex, food)? Yes / No

If yes, please list;

Females, are you pregnant? Yes / No

Do you smoke/vape? Yes / No If yes, how many per day? Would you like to stop? Yes / No

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

Signature: .

Please print name: Date: .