YOU AND YOUR FAMILY — CHILD

PATIENT'S DETAILS

Full name: _____ Date of birth: _____.

Address: _____ Post code: _____.

Child's email address: _____ Child's phone: (M) _____.

School/ University/ Occupation: _____ Hobbies and interests: _____.

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1: _____ Title: Mr/ Mrs/ Ms/ Dr/ Miss/ Other _____

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

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

Email Address: _____.

Parent/Guardian 2: _____ Title: Mr/ Mrs/ Ms/ Dr/ Miss/ Other _____

Address: (As above/Other) _____ Post Code _____.

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

Email address: _____.

CORRESPONDENCE TO BE SENT TO: PARENT 1 / PARENT 2 / BOTH

Name of person(s) responsible for fees: _____.

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)? Yes / No

If yes, please list:

Do you wish to discuss any medical aspects in private (i.e. without the patient)? Yes / No

To assist with growth assessment, please advise if the patient has reached puberty Yes / No

Females- has menstruation started? Yes / No . If so, how long ago did it start? Males- has voice changed? Yes / No

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place my child at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my child's treatment may need to be sent to other dental practitioners to aid them in my treatment and I consent to this. I also 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 child's treatment.

Parent/Guardian or Signature: .

Please print name: .

Relationship to patient: Date: .

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