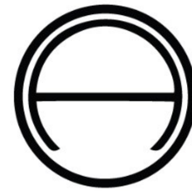
Patient Information and Medical History



AUSTIN
ORTHODONTICS

Personal Information

Title: *Master / Mr / Miss / Ms / Mrs / Dr / Other (please specify):* ______________

Given name: ______________ Surname: ______________

Preferred name: ______________ Date of birth: ___/___/______

Gender: *Female / Male / Other* Pronouns: ________ Email: ______________

Home address: ______________

Suburb: ______________ State: ______ Postcode: ________

Phone (home): ______________ Phone (mobile): ______________

Phone (work): ______________ Occupation: ______________

Emergency Contact

Emergency contact full name: ______________ Relationship: ______________

Contact number/s: ______________

Health Fund (We are unable to process any health insurance claims (HICAPS)

Do you have private health insurance for orthodontics? ☐ Yes ☐ No If **YES**, health fund name: ______________

Financial Responsibility:

Who is responsible for fees? ☐ Self ☐ Other If **OTHER**, relationship to patient: ______________

First name: ______________ Last name: ______________

Parent's/Guardian's Information (If patient is under 18)

Parent/Guardian 1

First name: ______________ Last name: ______________

Contact number/s: ______________ Relationship to patient: ______________

Email address: ______________

Parent/Guardian 2

First name: ______________ Last name: ______________

Contact number/s: ______________ Relationship to patient: ______________

Email address: ______________

Referral (How did you hear about us?)

☐ General dentist ☐ Current or former patient ☐ Facebook ☐ Signage
☐ Dental specialist ☐ Family member / friend ☐ Instagram ☐ Word of mouth
☐ Doctor ☐ Invisalign website ☐ Google ☐ Other, please specify: ______________

If applicable, please provide name: ______________

General Dental Information:

Clinician name: ______________________________ Contact number: ______________________

Clinic name: ______________________________________ Suburb: ______________________

Have you had a check-up and clean in the last 6 months? ☐ Yes ☐ No

Questionnaire

- What is your main concern regarding your teeth? ______________________________
- Have you had previous orthodontic treatment? ☐ Yes ☐ No
- Have you had an orthodontic consultation elsewhere? ☐ Yes ☐ No
- Do you have a history of past or present habits (*thumb-sucking, lip biting, tongue thrusting*)? ☐ Yes ☐ No
  If **YES** please specify: ____
- Any history of trauma to teeth, mouth or face? ☐ Yes ☐ No
  If **YES**, please specify: ____
- Any other significant dental history (*root canal treatment, missing teeth, TMJ)?* ☐ Yes ☐ No
  If **YES**, please specify: ____
- Are you happy to be contacted by Austin Orthodontics via email regarding practice news and marketing? ☐ Yes ☐ No

Medical Information

Do you have or have you ever suffered from any of the following? Please indicate:

If you are unsure about anything please discuss with your dental practitioner.

Have you ever stayed in hospital, had an operation or a general anaesthetic? If **YES**, please specify: ______________________	☐ Yes ☐ No	Do you smoke or have you ever been a smoker? If **YES,** how many per day: _________ and for how long: _________	☐ Yes ☐ No
Any heart complaints / condition / murmur / pacemaker?	☐ Yes ☐ No	Any joint problems / arthritis / history of joint replacement surgery?	☐ Yes ☐ No
Blood pressure: high / low	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes: type I / type II	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Radiation therapy / chemotherapy	☐ Yes ☐ No	Kidney problem	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Asthma / bronchitis / lung conditions	☐ Yes ☐ No
HIV / AIDS	☐ Yes ☐ No	Anxiety / depression / other	☐ Yes ☐ No
Osteoporosis / bisphosphonate therapy	☐ Yes ☐ No	Do you take recreational drugs?	☐ Yes ☐ No
Stroke / seizures / other neurological	☐ Yes ☐ No	Are you a blood donor?	☐ Yes ☐ No
Blood disorder / excessive bleeding If **YES**, please specify: _______________	☐ Yes ☐ No	Liver problems / hepatitis If **YES**, please specify: _______________	☐ Yes ☐ No
Growth problems / birth defects If **YES**, please specify: _______________	☐ Yes ☐ No	*For women only:* Are you pregnant If **YES**, when are you due: ____________	☐ Yes ☐ No

Do you have any allergies or had a reaction to medications or latex? If **YES**, please specify: ____	☐ Yes ☐ No
Have you ever had any serious problems after dental treatment? If **YES**, please specify: ____	☐ Yes ☐ No
Any other medical conditions? If **YES**, please specify: ____	☐ Yes ☐ No
Are you currently taking any medications or tablets regularly? If **YES**, please specify below	☐ Yes ☐ No

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Privacy Policy and how we treat your information

- Austin Orthodontics (AO, we, us) respects your privacy and is committed to protecting your health and personal information. Our privacy policy (available on our website or upon request) outlines our approach to privacy and how we collect, use, disclose and protect your health and personal information and sets out your rights in relation to accessing the information we hold about you.
- We may from time to time be bound by the *Privacy Act 1988* (Cth), *Health Records Act 2001* (Vic) and the *Privacy and Data Protection Act 2014* (Vic) or any other acts or regulations that govern the management, collection, use, disclosure, and storage of personal or health information.
- AO only collects Information we need to perform our functions and you acknowledge, agree and consent to us collecting health information for the purposes of providing you with orthodontic services. Health information we may collect and you consent to us collecting may include:
  - Personal, medical and or dental reports and history from your medical or dental practitioners and health care providers;
  - Treatment notes, reports and radiological information;
  - Financial information in circumstances where credit is provided for our services;
  - Details of your private health insurance provider;
- We may disclose your health information for the purposes of providing you with orthodontic services, including to provide health information to your dentist, specialist, GP or to your referring health practitioner. You are able to request this does not occur by providing this in writing to us.
- We may otherwise make your personal and health information available to another health service provider if requested by you.

By signing this form, you agree to our privacy policy. Furthermore, you agree that the personal and health information you have provided herein is true and correct, to the best of your knowledge, and you understand that any failure to disclose information may be detrimental to your treatment.

Parent / Guardian Name (Please Print): ______________________________________

Signature: *x*.. **Date:** ___/___/_______

Clinician Signature:

x...................................