



Patient History

FULL NAME:		
Mr/Mrs/Ms/Miss/Master		
Date of Birth:	/ /	Age: Years & Months
Home Address:		Postcode:
Telephone: Home:	Work Ph:	Mobile:
Primary/High School/College attending or Occupation:		

PARENT DETAILS: (if patient is under 18 years):		
Father:		
Address (as above/other):		Post Code:
Occupation:	Work Ph:	Mobile:
Mother:		
Address (as above/other):		Post Code:
Occupation:	Work Ph:	Mobile:

PARTY RESPONSIBLE FOR FEES:		
Account Names/s:		
Name of Private Health Fund/Insurance Co.:		
Family Dentist:		
Family Medical Practitioner:		
School Dentist:		
School Dental Clinic:		
Who referred you to us?		

PREVIOUS ORTHODONTIC HISTORY:		
Consultations:		
Treatment (eg: plates/braces):		
Extraction of Teeth:		

HABITS:		
Please read and cross out that which does not apply:		
Mouth Breathing: Always/Sometimes/Never		
Nose Breathing Problems: Yes/No		
Thumb/Finger Sucking: Never/Current/Given up at age years.		

Have you suffered any serious illnesses? Yes/No		
Have you had an adverse reaction to any treatment or medication? Yes/No		
Do you take drugs/medication regularly? Yes/No		
Have you had any injuries/operations in the head or neck area? Yes/No		
Do you have any bleeding problems or heart conditions? Yes/No		
Do you need prophylactic antibiotic cover for dental treatment? Yes/No		

The AIDS and the HEPATITIS B virus may be transmitted through blood and saliva. This puts the dentist and staff in a vulnerable position when attending patients who fall into the "high risk" category of either disease. "High risk" categories have been identified as: Patients who have contracted the Hepatitis B or C, Patients who have contracted HIV or AIDS, Users of intravenous drugs of addiction, Recipients of blood or blood products, Homosexuals and Bisexuals, Sexual Partners of any of the above.

PLEASE CIRCLE THE APPROPRIATE ALTERNATIVE:

- (NO): I am not in the "high Risk" category.
- (YES): I am/could be in the "High Risk" category.

If the answer is yes, special precautions will be taken to protect you, other patient's and staff.

SIGNATURE.....
Parent/Guardian/Self

TODAY'S DATE.....**DAY**.....**MONTH**.....**YEAR**

Authority and Acknowledgement

West Lakes/Glenelg/Nuriootpa

I/WE.....
Self/The Parent(s)

hereby authorise you to provide orthodontic services to myself/my/our child

.....

as you consider necessary or desirable and as agreed to by myself/ourselves. I/WE hereby agree to be responsible for the payment of your professional fees for such services.

"In the case where both parents or guardians of the patient sign this form it is hereby acknowledged and agreed by such parents or guardians that they accept and undertake joint and several liability for the professional fees and expenses of and incidental to the dental services rendered to the patient, notwithstanding whether the account for such fees and expenses is in one or both of names of such parents or guardians."

TODAY'S DATE.....**MONTH**.....**YEAR**

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SIGNATURE OF PARENT OR GUARDIAN