Bendigo ORTHODONTIC SPECIALISTS

Medical History Questionnaire

Patient Details

Title: _____ Legal First Name: _____ Surname: _____ Date of Birth: ____ / ____ / _____

Preferred name: _____ Address: _____ Suburb: _____

Postcode: _____ Phone : _____ Email: _____

Sex at birth: _____ Gender: _____ Pronouns: _____

Occupation: _____ Medicare No: _____ Individual Reference: ___ Expiry: _____

Emergency Contact Name: _____ Emergency phone number: _____

Do you play contact sport? ☐ Yes ☐ No Details: _____ School (if applicable):_____

Orthodontic concern: _____ Appointment reminder preference: ☐ Email ☐ SMS

Person Responsible for Account (if different to above)

Title: _____ First Name: _____ Surname: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Email: _____ Relationship to Patient: _____

Dental History

Family Dentist: _____ Last Dental Exam: _____

Health insurance ☐ Yes ☐ No Health fund: _____ Health fund member number: _____

Have you ever had:

- **Deep filling / root canal? ☐ Yes ☐ No**
- **Trauma to teeth (knocked badly)? ☐ Yes ☐ No**
- **Injuries to face/jaw/teeth? ☐ Yes ☐ No**
- **Gum issues / treatment? ☐ Yes ☐ No**
- **Jaw clicking? ☐ Yes ☐ No**
- **Jaw pain (ear/face)? ☐ Yes ☐ No**
- **Difficulty opening/closing? ☐ Yes ☐ No**
- **Difficulty chewing? ☐ Yes ☐ No**
- **Tooth grinding/clenching (bruxism)? ☐ Yes ☐ No**
- **Snoring / airway issues? ☐ Yes ☐ No**

Medical History

Doctor Name & Phone: _____

Do you have / have you had:

☐ Arthritis ☐ Difficulty swallowing ☐ Osteoporosis ☐ Bone disorder

☐ **Hepatitis B or C** ☐ **Prolonged bleeding** ☐ **Diabetes** ☐ **HIV/AIDS**

☐ **Dental anxiety** ☐ **Asthma** ☐ **COPD** ☐ **Sleep apnoea**

☐ **High blood pressure** ☐ **Heart murmur/defect** ☐ **Stroke** ☐ **Rheumatic fever**

☐ **Pregnant** ☐ **Physical/sensory/learning disability** ☐ **Smoker** ☐ **Ex-smoker since:_____**

☐ **Vaper** ☐ **Ex-vaper since: _____** ☐ **Valve replacement/Pacemaker** ☐ **Anticoagulant medication**

☐ **Joint replacement** ☐ **Bisphosphonate medication/injections** ☐ **Allergic to medication/metals/ latex/foods**

Additional details

Serious illness: _____ **Current medications: _____**

Allergies: _____ **Disability details: _____**

Orthodontic History

Previous orthodontic treatment? ☐ **Yes** ☐ **No** **Teeth removed for crowding?** ☐ **Yes** ☐ **No**

Family orthodontic treatment? ☐ **Yes** ☐ **No** **Family jaw surgery/advised?** ☐ **Yes** ☐ **No**

Use of Artificial Intelligence (AI) for Clinical Documentation

As part of our commitment to efficient, high-quality orthodontic care, Bendigo Orthodontic Specialists uses a secure, Australian-based privacy-compliant artificial intelligence (AI) tool to assist our team with preparing clinical notes during or after your consultation. This tool is always supervised by your treating orthodontist or oral health therapist and is used solely to support accurate documentation of your orthodontic treatment. By attending Bendigo Orthodontic Specialists, you acknowledge and consent to the use of this AI tool for clinical documentation. All information handled via this tool is managed in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles, ensuring your data remains secure, confidential, and used only for permitted purposes. Please visit our website to review the Terms and Conditions of Bendigo Orthodontic Specialists.

If you have any concerns or questions regarding the use of AI within our practice, please speak to reception.

Privacy Policy & Terms of Payment

I have completed this questionnaire to the best of my knowledge, and I understand that failure to make a full disclosure may place me at undue risk. I understand it is my responsibility to update the orthodontist and practice of any personal, medical, dental health and financial changes that arise while under the care of Bendigo Orthodontic Specialists.

I understand that notes, X-Rays and/or scans relating to my treatment may need to be sent to other dental practitioners to aid in my treatment and I consent to this. I also give permission for the practice to send me appointment reminders using the contact details supplied.

I have read the terms and conditions of Bendigo Orthodontic Specialists (on our website) and acknowledge Bendigo Orthodontic Specialists implement late cancellation/missed appointment fees.

I accept responsibility for my account and understand that any required fees are payable on the day of the appointment.

Patient/Guardian Name: _____

Signature: _____

Date: ____ / ____ / _____