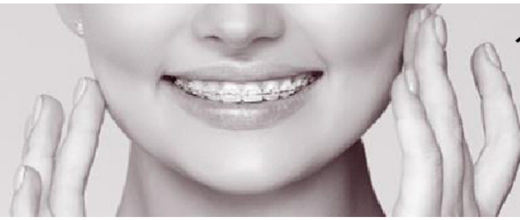
CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE



PATIENT DETAILS

Title ………… First name ………………………..………………..
Surname ………………………………………………………..
Address ………………………………………………………………………………………..
Suburb ………………………………….... Postcode ……………………………
Phone M …………………. H …………………… W ………………
Email ………………………………………………………………………………………..
Date of birth ………/……………/…………………… Gender *M F Other*
Medicare no. ………………………….. Individual reference no. …………………………...
Expiry date ………………………………………………………………………………………..
Occupation ………………………………………………………………………………………..
Emergency contact Name……………………….............. Phone …………………………………..
Do you play any contact sport? Yes ☐ No ☐ Details ……………………………………….
School *(If applicable)* ……………………………………………………………
Appointment reminder preference Email ☐ SMS ☐

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

Title ………. First name ………………………………………
Surname …………………………………………………
Address ………………………………………………………………………………………..
Suburb ………………………………………… Postcode ………………………………
Phone M ……………… H ……………………… W ………………..
Email ………………………………………………………………………………………..
Relationship to patient ………………………………………………………………………………………..

DENTAL HISTORY

Family Dentist ……………………………………………………………………………..
When was your last dental examination? ………………………………………………
Do you have health insurance with extras for orthodontic treatment? Yes ☐ No ☐
Healthcare provider/ member no. ………………………………………………………….
Healthcare provider / member IRN. ………………….
Have you ever had a deep filling or nerve removed from a tooth? Yes ☐ No ☐
Have you ever had any trauma to your teeth (knocked your tooth badly)? Yes ☐ No ☐
(Details) ……………………………………………………………………….
Have you ever suffered from any injuries to the face, jaw or teeth? Yes ☐ No ☐
Have you ever had any gum issues and/or gum treatment? Yes ☐ No ☐
Have you ever experienced any of the following jaw problems: *(Please tick)* Yes ☐ No ☐

Clicking of the jaw ☐ Pain in the jaw, ear, or side of face ☐ Difficulty opening or closing your mouth ☐ Difficulty chewing ☐

MEDICAL HISTORY

Have you suffered from: (*please circle / tick)*

Arthritis	Difficulty swallowing	Osteoporosis
Bone disorder	Hepatitis B or C	Prolonged bleeding
Diabetes	HIV/AIDS	Dental anxiety

Do you/ Have you ever suffered from a serious illness? Yes ☐ No ☐

(Details)…………………………………………………………………………

Are you under medical care or taking any medication? Yes ☐ No ☐

(Details)………………………………………………………………………………………..

Do you have a heart murmur or heart defect? Yes ☐ No ☐

Have you ever taken bisphosphonate mediation or injections? Yes ☐ No ☐

Are you allergic to any medication, metals or latex? Yes ☐ No ☐

(Details)………………………………………………………………………………………..

Are you pregnant? Yes ☐ No ☐

Do you have any physical, sensory or learning disabilities? Yes ☐ No ☐

(Details)………………………………………………………………………………………

Are you a smoker? Yes ☐ No ☐

Are you an ex-smoker? Yes ☐ No ☐

How long did you smoke for? ………………………………

When did you quit smoking? ....

Do you vape? Yes ☐ No ☐

Are you an ex-vaper? Yes ☐ No ☐

How long did you vape for? ………………………………

When did you quit vaping? ....

ORTHODONTIC HISTORY

Have you ever had previous orthodontic treatment? Yes ☐ No ☐

Have you had any teeth removed for crowding? Yes ☐ No ☐

Has any other member of the family had orthodontic treatment? Yes ☐ No ☐

(Details)………………………………………………………………………………………..

Has any member of the family had jaw surgery or has been advised they need jaw surgery? Yes ☐ No ☐

What are your reasons for seeking an orthodontic opinion/ orthodontic treatment?

(Details)………………………………………………………………………………………..

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 doctor 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 and check-up reminders using the contact details supplied.

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

Patient/Guardian name: ………………………………………………………………………………………..

Patient/Guardian signature: ……………………………………

Date: ……………………………