Bendigo ORTHODONTIC SPECIALISTS

**CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE**

## PATIENT DETAILS

Title Dr ☐ Mr ☐ Mast ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname …… First Name ……

Preferred Name ..... Date of Birth .....

Address .....

Suburb …… Postcode ……

Phone Mobile …… Home …… Work ……

Email ……

Medicare Number ..... Individual Ref No ..... Expiry Date .....

Occupation .....

Emergency contact Name…… Phone ……

Do you play any contact sport? Yes ☐ No ☐ Details ……

Childs school *(If applicable)* ……

Appointment reminder preference Email ☐ SMS ☐

## PERSON RESPONISBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

Title Dr ☐ Mr ☐ Mast ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname ..... First Name .....

Address ……

Suburb …… Postcode ……

Phone Mobile …… Home …… Work ……

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 ☐

Health Insurance Provider ……

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 ☐

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: Yes ☐ No ☐

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



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**MEDICAL HISTORY**

Have you ever suffered any of the following illnesses:

| | | | | | |
|---|---|---|---|---|---|
| Arthritis | ☐ | Difficulty swallowing | ☐ | Osteoporosis | ☐ |
| Bone disorder | ☐ | Hepatitis B or C | ☐ | Prolonged bleeding | ☐ |
| Diabetes | ☐ | HIV/AIDS | ☐ | Are you a smoker? | ☐ |

Have you ever suffered 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 medication or injections? Yes ☐ No ☐

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

*(Details)*……..

Are you pregnant? Yes ☐ No ☐

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

*(Details)*……..

**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 and/or jaw surgery?

*(Details)*……..

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 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 further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.
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 ……