CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Bendigo ORTHODONTIC SPECIALISTS

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: ……