



Welcome to our Practice

PATIENT SURNAME: _____ **FIRST NAME:** _____ **MR/MRS/MS/MISS/MST/DR**

PREFERRED NAME: _____ **REFERRED BY/Usual Dentist:** _____

AGE _____ **DATE OF BIRTH** _____ **SEX** _____

Home Address _____ **Mailing address(if different)** _____

Suburb _____

Postcode _____

		Person Responsible for Payment	Self ()
Telephone	Home _____		Parents ()
	Work _____		Mother ()
	Mobile _____		Father ()
	Other mobile _____		Other ()

IF APPLICABLE:
School/Uni _____

Mother's name in full _____ **Occupation:** _____

Father's name in full _____ **Occupation:** _____

EMAIL ADDRESS

MEDICAL HISTORY Please indicate any of the following:

Diabetes ()	Rheumatic Fever ()	AIDS ()
Epilepsy ()	Endocrine Problems ()	Hepatitis ()
Asthma ()	Cold Sores/Herpes ()	Tonsil removal ()
Fainting ()	Bone Disorder ()	Adenoid removal ()
Heart Condition ()	Excessive Bleeding ()	

Current Medications _____

ALLERGIES _____

DENTAL HISTORY

Past injuries to face _____

Thumb or finger sucking _____

Mouth Breathing _____

Teeth Grinding _____

Extra or Missing Teeth _____

Does Patient Desire Treatment? _____

Have other Family Members had Orthodontic Treatment?

Has an Orthodontist been consulted previously? Yes()No()

Sports and Hobbies _____

Other Relevant Information? _____

Private Health Insurance Details _____ **Signature** _____ **Date** _____

Please complete this form and bring it with you to the appointment.

Office use only Scanned

Entered

We look forward to seeing you then.