FACE TO FACE
ORTHODONTICS

Adult Form

To enable us to diagnose and treat you to the highest possible standard, please complete all sections of this form as accurately as possible. This and all records are protected by the Privacy Amendment Act 2000.

I have confidential medical information that I only wish to discuss with the orthodontist, I do not wish to write it down.

☐ Yes ☐ No

Patient Details

Patients Name: (LAST NAME) ____________________ (FIRST NAME) ____________________

(Mr,Mrs,Miss,Ms) Preferred Name (If Different from Above) ____________________

Date Of Birth: ____________________ Gender M/F/Other: ____________________

Address: ____________________ Suburb: ____________________ Post Code: ____________

Contact Mobile Number: ____________________ Contact Email: ____________________

Emergency or Alternative Contact Name & Mobile Number: ____________________

Occupation/Place of Work: ____________________

Name of General Dentist/ Dental Clinic: ____________________

Person responsible for account: ____________________

Name of Private Health Insurance (if any): ____________

Do you have a referral from your dentist? ☐ Yes ☐ No

Medical History

Yes No

☐ ☐ Are you currently taking any medication? If yes please list:

____

☐ ☐ Have you previously had or currently have any chronic health issues? If yes, please describe:

____

☐ ☐ Do you have any airway, breathing , snoring or sleep apnoea issues? If yes, please describe:

____

☐ ☐ Do you suffer from any nervous issues or psychological problems? If yes, please describe:

____

☐ ☐ Are you Allergic to anything? If yes please list:

____

☐ ☐ Are you currently under the care of any specialist medical practitioner? If yes please describe:

____

Do you have any of the following:

Yes	No	
☐	☐	• *ADD/ADHD*
☐	☐	• *Arthritis or joint issues?*
☐	☐	• *Asthma*
☐	☐	• *ASD/Asperger's*
☐	☐	• *Blood/Bleeding Disorders*
☐	☐	• *Cancer*
☐	☐	• *Cleft Lip or Palate*
☐	☐	• *Congenital Birth Defects/Syndromes*
☐	☐	• *Depression*
☐	☐	• *Diabetes*
☐	☐	• *Epilepsy*
☐	☐	• *Heart or Blood Pressure Problems*
☐	☐	• *Hepatitis B/HIV*
☐	☐	• *Immune system issues*
☐	☐	• *Kidney or Liver problems*
☐	☐	• *Osteoporosis*
☐	☐	• *Previous major surgery*
☐	☐	• *Rheumatic Fever*
☐	☐	• *Speech or Hearing problems*
☐	☐	• *Thyroid disease*

Yes	No	
☐	☐	Are you pregnant?
☐	☐	Do you smoke cigarettes?
☐	☐	Do you currently consider yourself in good health?

Dental History

Yes	No	
☐	☐	Chronic Mouth Breathing
☐	☐	Clenching or Grinding of Teeth
☐	☐	Dental or Facial Trauma
☐	☐	Frequent Mouth Ulcers
☐	☐	Gum Disease
☐	☐	Jaw Joint (TMJ) clicking or locking
☐	☐	Oral Habits
☐	☐	Previous Orthodontic Treatment
☐	☐	Tooth Decay or Fillings
☐	☐	Wisdom tooth extractions

Is there any other relevant medical/dental history that should be brought to our attention?

____

Approximate date of last general dental check and clean: ____________________

Regularity of General Dental Checks: ☐ **Six Monthly** ☐ **12 Monthly** ☐ **Irregular**

What are the main concerns about your teeth/smile?

____

All medical information is treated with complete professional confidentiality.

In signing this form, I acknowledge that I have endeavoured to answer all questions as accurately as possible. I will supply my orthodontist with any changes to this medical history should they arise.

Signed ______________________________ Date ______________