FACE TO FACE
ORTHODONTICS

Child/Adolesent 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 about my child 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: _____

School: _____ Year : _____

Mothers Name: (LAST NAME) _____ (FIRST NAME) _____

Address: (If Different from Above) _____

Phone (H): _____ Phone (W): _____

Contact Mobile Number: _____ Contact Email: _____

Fathers Name: (LAST NAME) _____ (FIRST NAME) _____

Address: (If Different from Above) _____

Phone (H): _____ Phone (W): _____

Contact Mobile Number: _____ Contact Email: _____

Patients General Dentist/Dental Clinic: _____ Phone: _____

Patients Doctor : _____ Phone: _____

Person responsible for Account: _____

Name of Private Health Insurance (if any): _____

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

Has/is your child

Yes	No	
☐	☐	Previously had or currently having any chronic health problems? If yes, please describe:
☐	☐	Currently under the care of any specialist medical practitioners? If yes, what for:
☐	☐	Allergic to anything? If yes, please list:

Has/is your child

Yes No

☐ ☐ Currently taking any regular medications? If yes, please list:

_____

☐ ☐ Have any airway/breathing/snoring/sleep apnoea issues? If yes, please describe:

_____

☐ ☐ Have tonsils and/or adenoids been removed? If yes, when:

_____

Does your child have any of the following health issues?

Yes No

☐ ☐ ADD/ADHD
☐ ☐ Asthma
☐ ☐ ASD/Aspergers
☐ ☐ Blood/Bleeding Disorders
☐ ☐ Cleft Lip or Palate
☐ ☐ Congenital Birth Defects/ Syndromes
☐ ☐ Depression or other psychological problems
☐ ☐ Diabetes
☐ ☐ Epilepsy
☐ ☐ Heart or Blood Pressure Problems
☐ ☐ Rheumatic Fever
☐ ☐ Hepatitis B/HIV
☐ ☐ Juvenile Arthritis
☐ ☐ Kidney or Liver problems
☐ ☐ Speech, learning or hearing problems

Please note any relevant information or other medical conditions not listed above that should be brought to our attention.

Dental History - Has your child had any of the following?

Yes No

☐ ☐ Chronic Mouth breathing
☐ ☐ Clenching or Grinding of Teeth
☐ ☐ Dental or Facial Trauma
☐ ☐ Frequent Mouth Ulcers
☐ ☐ Jaw Joint (TMJ) clicking or locking
☐ ☐ Persistent Thumb or Finger Sucking
☐ ☐ Previous Orthodontic Treatment
☐ ☐ Previous Speech Therapy
☐ ☐ Tooth Decay, Fillings or Extractions

Please note any relevant information or other dental issues not listed above that should be brought to our attention.

Approximate date of last general dental check and clean: _____

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

_____

What are your main concerns about your child's teeth?

_____

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 _____