YOU AND YOUR FAMILY

Patient's full name: Date of birth:

Address:

Post code: Phone: (H)

School:

Hobbies and interests:

Parent 1: Title: ☐Mr ☐Mrs ☐Ms ☐Dr☐ Miss ☐Other

Address: (Complete only if different to child)

Post code:

Phone: (H) Phone: (W) Mobile:

Email Address:

Parent 2: Title: ☐Mr ☐Mrs ☐Ms ☐Dr☐ Miss ☐Other

Address: (Complete only if different to child)

Post code

Phone: (H) Phone: (W) Mobile:

Email Address:

Name of person(s) responsible for fees:

Do you have dental insurance? Yes☐ No☐ If yes, which fund?

How did you find out about us? ☐ Family dentist ☐ Yellow pages ☐ Friend

☐ Relative ☐ Website ☐ Other

YOUR DENTAL HEALTH

What is your dentist's name?

Address:

Post code: Phone:

When was your last dental examination?

Have you ever had any injuries to the face, mouth or teeth? ☐Yes ☐ No

Have you ever sucked a thumb or fingers? Until what age? ☐ Yes ☐ No

Do you have any speech problems? ☐ Yes ☐ No

Do you have any jaw problems (e.g clicking, locking)? ☐ Yes ☐ No

Have you ever had any serious problems with dental treatment? ☐ Yes ☐ No

Does anyone else in the family have an orthodontic problem? ☐Yes ☐ No

Has anyone else in the family had orthodontic treatment? ☐ Yes ☐ No

What is your main concern regarding your teeth?

Pure Orthodontics ABN 56102 231 256
Suite 1B, Level 2, 12 Hall Street, Moonee Ponds, Victoria, 3039 I **phone** 9370 3155 I **fax** 9370 3051
email info@pureorthodontics.com.au
www.pureorthodontics.com.au

YOUR GENERAL HEALTH

What is your doctor's name? _____

Address: _____

Post code: _____ Phone: _____

Have you ever had any of the following:

Asthma or breathing problems ☐Yes ☐ No
High blood pressure ☐Yes ☐ No
Heart problems ☐Yes ☐ No
Rheumatic fever ☐Yes ☐ No
Autism Spectrum Disorder ☐Yes ☐ No
ADHD / Behavioural Issues ☐Yes ☐ No
Tuberculosis ☐Yes ☐ No
Stomach or bowel problems ☐Yes ☐ No
Kidney disease ☐Yes ☐ No
Diabetes ☐Yes ☐ No
Thyroid problems ☐Yes ☐ No
Excessive bleeding or blood disorder ☐Yes ☐ No
Epilepsy ☐Yes ☐ No
Hepatitis ☐Yes ☐ No
AIDS/HIV ☐Yes ☐ No
Joint problems or arthritis ☐Yes ☐ No

List any other previous illnesses _____

Are you currently taking any tablets or medicines? ☐Yes ☐ No

If yes, please list _____

Have you ever stayed in hospital, had an operation, or a general anaesthetic? ☐Yes ☐ No

If yes, please provide details _____

Do you have an artificial hip, heart valve or other prosthetic implant? ☐Yes ☐ No

Are you allergic to any medicines or products (e.g. penicillin, latex)? ☐Yes ☐ No

If yes, please list _____

Females, have you had your first period? If so what year? _____

Females, are you pregnant? ☐Yes ☐ No

Do you smoke? ☐Yes ☐ No How many? /day Would you like to stop? ☐Yes ☐ No

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and I consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check-up reminders.

Parent/Guardian or Signature: _____

Please print name: _____

Relationship to patient : _____ Date: _____

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