PATIENT INFORMATION FORM

THE ORTHODONTIC SPECIALISTS
Improving your smile

Patient Title: Mr □ Mrs □ Ms. □ Miss □

SURNAME..... FIRST NAMES.....

DOB..... SCHOOL ATTENDING.....

RESIDENTIAL ADDRESS.....

SUBURB .....POST CODE……..

POSTAL ADDRESS (If different from above)……..…

PHONE..... MOBILE..... WORK …….

RESPONSIBLE PARTIES- If a patient is a minor (under the age of 18) please indicate who is financially responsible and provide details of persons contactable regarding treatment or attending appointments.

Please discuss account options with reception staff where more than one person is responsible for accounts

RESPONSIBLE PARTY No: 1
Financially responsible (please tick) □
RELATIONSHIP TO PATIENT…….
Mr □ Mrs. □ Miss □ Ms □ Dr □

NAME.....

ADDRESS.....

MOBILE.....

EMAIL…….

RESPONSIBLE PARTY No: 2
Financially responsible (please tick) □
RELATIONSHIP TO PATIENT…….
Mr □ Mrs. □ Miss □ Ms □ Dr □

NAME.....

ADDRESS.....

MOBILE.....

EMAIL……..

NAMES OF ANY CHILDREN/RELATIVE PREVIOUSLY TREATED BY THIS PRACTICE

1..... 2.....

WHO SUGGESTED YOU ATTEND THIS PRACTICE?

WHO IS YOUR: (1) DENTAL PRACTITIONER.....

(2) MEDICAL PRACTITIONER.....

EMERGENCY CONTACT NAME:.....MOBILE..... PHONE.....

MEDICAL HISTORY.
Are you at present receiving any medical attention? Yes □ No □
Are you taking any medicine or tablets? Yes □ No □
If yes, please list medication:..... .....
HAVE YOU HAD ANY OF THE FOLLOWING? Please Tick if the answer is 'YES'

Diabetes □
Heart problems □
Rheumatic Fever □
High Blood Pressure □
Arthritis □
Epilepsy □
Kidney Disease □
Hepatitis & Other Viral Diseases □
Bleeding Disorders □
Asthma □
Allergic reactions□ (if yes please specify below)
……..……

Other…..
Have you ever had any other serious illness? YES □ NO □ If the answer is 'YES' please list names ..... …..
Female patients, do you believe you are or may be pregnant? YES □ NO □
Have you ever had any problems with Dental treatment? YES □ NO □

On future visits if there are any changes to the above information please advise staff as applicable

SIGNATURE.....**DATE** .....

NAME .....

PARENT/GUARDIAN SIGNATURE IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE**)**