ORTHODONTICS

CHILD PATIENT INFORMATION & MEDICAL HISTORY FORM

Title:______ Patient's Surname ____________________ First Name__________________ Common Name _______________

Gender: ❑ Male ❑ Female ❑ Other ________________Date of Birth____________ Age: ________

Home Address ____Post Code__________

Telephone: Home_____________________________ Work______________________ Mobile___________________________

Child's email__________________________________ Patient School/University/Occupation: ______________________

Other family members in the practice____

Patient's Dentist name & address ____

Has the patient had a checkup and/or clean recently?❑YES ❑NO

Does the patient have Dental Insurance for Orthodontics?❑YES ❑NO Which Fund? _____________________________

Who can we thank for referring you?

Dental Practitioner
- ❑ Dentist
- ❑ Dental therapist/hygienist
- ❑ Oral Surgeon
- ❑ Periodontist
- ❑ Prosthodontist
- ❑ Periodontist

Please name Doctor:_____________

Other_____________________

Internet
- ❑ Influencer
- ❑ Facebook
- ❑ Instagram
- ❑ Internet **Please Check** Google❑ Bing❑ Yahoo❑

Other_________________
- ❑ Invisalign website
- ❑ The Invisible Orthodontist

Word of mouth
- ❑ Patient - Friend

Name_________________
- ❑ Patient - Family member

Name_________________
- ❑ Parent of patient

Name_________________
- ❑ Word of mouth ________________

Advertisement
- ❑ School Advertisement

Specify_________________
- ❑ Signage

Specify_________________
- ❑ Sponsorship

Specify_________________
- ❑ Newspaper
- ❑ Other_________________

Parent Details

Correspondence to be sent to: Parent/Guardian 1 ❑ Parent/Guardian 2 ❑ Both ❑

Parent/Guardian1: Title:______ Name: ____

Address (As above/Other) ____Post code:_______

Home phone (As above/Other)____ Work phone: __________________________

Mobile: ______________________________________ Email: ____

Parent/Guardian2: Title:______ Name: ____

Address (As above/Other) ____Post code:______

Home phone (As above/Other)____ Work phone: __________________________

Mobile: ______________________________________ Email: ____

Person responsible for fees:

❑ Parent / ❑ Other – Relationship to Patient _____________________________

Contact details **if not Parent**: Name (include title) ____

Address ____

Mobile Phone________________________________ Home Phone__________________ Work Phone_________________

Patient's Dental History:

Have any teeth been extracted?❑YES ❑NO❑UNSURE Any missing permanent teeth?❑YES ❑NO❑UNSURE

History of trauma to teeth, mouth or face ____

Past or present habits (e.g. thumb/finger sucking, tongue thrusting, lip biting, etc.)______________________________

Past orthodontic consultation ❑YES ❑NO Past orthodontic treatment (e.g. plates/braces)_______________________

Other significant dental history (e.g. missing teeth, root canal, TMJ) ____

Main concerns about patient's teeth? ____

Please go to the next page

Patient's Medical History: (Please tick where applicable)

❑ Asthma	❑ Birth defects	❑ Bleeding disorders	❑ Bone disorders
❑ Diabetes	❑ Epilepsy	❑ Growth problems	❑ Autism
❑ Heart murmur	❑ Heart disease	❑ Hepatitis	❑ Developmental differences ____________________
❑ HIV / AIDS	❑ Kidney disease	❑ Allergies__________	❑ Mental health concerns ______________________

❑ Other____________________________________

❑ Current Medication ____

If you wish to discuss any medical aspects in private (ie: without the patient), please tick box: ❑

To assist with assessing growth, has the patient reached puberty?

Girls- Has menstruation started? ❑Yes ❑ No

Boys- Has voice changed? ❑Yes ❑ No

To the best of my knowledge, the information on the previous page is complete and correct.

Parent Signature ________________________________ Name ______________________________________ Date _____________

Privacy Policy

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988, we consider the protection of your privacy and personal information to be a high priority. Therefore, we realise that it is important that you are aware of why we collect, how we use and to whom we may disclose your information.

The policy of our practice is to follow these procedures:

- The information collected will be used for the purposes of providing treatment to you. Personal information such as your name, address and other details will be used for the purpose of accounts and payments and writing to you about your treatment and our services.
- We may disclose your health information to other health care professionals or require it from them if necessary for your treatment. In that event, disclosure of your personal details will be minimised.
- We may also use parts of your health information for research purposes in study groups or at seminars and lectures as this may be of benefit to other patients. Your personal identity will not be disclosed.
- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

We respect your privacy and this information will be held in the strictest confidence.

Please sign here as confirmation that you understand and consent to our privacy policy.

Parent Signature _____________________________ Name ______________________________________ Date ________________

Authority to request/refer records to health care providers

We may need to request records from your previous or current dentist or specialist to assist with your orthodontic treatment planning. We also correspond with and forward x-rays to your dentist or other specialists for treatment planning when required. During your treatment, we may need to refer you to other specialists. To ensure compliance with Federal and State Privacy Legislation we require your signed consent to work with other health care professionals.

❑ Permission to take diagnostic x-rays

Parent Signature ____________________________ Name ____ Date ________________