amanda lawrence
ORTHODONTIST

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For office use only:	Date:	Patient No:
	Date:	Scanned by:
	Date:	Plan entered by:

Patient Information

(please print in blue or black ink)

Last Name	First Name	Gender (circle) M / F	Birth Date	Age
Patient's Address		Suburb		Postcode
Home Phone	Mobile			
If over 18 years of age: Work Number	School (If student)			Grade
Dentist Name	Dentist Address			Date of last visit

Names of related patients that are or have been under our care and the relationship to the patient.	Names and ages of patient's other siblings.
1	1
2	2
3	3

Preferred email for correspondence / accounts, and mobile number for reminders by text message

Email	Mobile

Parent Information *(please complete if patient is under 18 years of age)*

PARENT / GUARDIAN (1)	PARENT / GUARDIAN (2)
Name	Name
Relationship to patient	Relationship to patient
Address (if different from patient)	Address (if different from patient)
Suburb Postcode	Suburb Postcode
Home Phone Mobile	Home Phone Mobile
Email	Email
Are you responsible for the accounts? Y / N	Are you responsible for the accounts? Y / N
Do you want correspondence sent to you? Y / N	Do you want correspondence sent to you? Y / N
If both parents are not joint guardians Are you the patient's legal guardian? Y / N If no, please advise name & address of guardian. If yes, may patient information be released to Parent/Guardian(2) ? Y / N	If both parents are not joint guardians Are you the patient's legal guardian? Y / N If no, please advise name & address of guardian. If yes, may patient information be released to the Parent/Guardian (1) ? Y / N

Medical History

Please tick if patient has or has had:

( ) Arthritis
( ) Heart problems
( ) Bleeding problems
( ) Infectious disease
( ) Epilepsy
( ) Bone disorders
( ) Birth defects
( ) Unusual childhood illness
( ) Behavioural/emotional problems
( ) Allergic reactions

Please provide more detail for positive responses

Any other serious illnesses

Current medications

Dental History

Please tick where response is positive:

( ) Any injuries to mouth / teeth? (circle)
( ) Thumb / finger sucking? (circle)
( ) More than average amount of decay?
( ) Any missing permanent teeth?
( ) Any teeth removed by extraction?
( ) Any significant jaw joint problem?
( ) Any braces or plates previously worn?
( ) Grinding teeth?
( ) Tongue thrust?

Reason for orthodontic consultation:

Estimate how much did the patient grow last year? (circle)

None Small amount (<5cm) A lot (>5cm)

Patient's attitude towards orthodontic treatment? (circle)

Excellent Good Fair No interest

To the best of my knowledge, the above information is complete and correct.

_____	_____	_____
Date	Signature of Patient (if over 18 years) or Parent /Guardian	Print Name

Privacy Information

Please sign here as confirmation that you have received and understood our privacy policy and that you consent to this.

_____	_____	_____
Date	Signature of Patient (if over 18 years) or Parent /Guardian	Print Name

Authority to Request/Refer Records to Other Health Care Professionals

We may need to request records from your previous or current dentist or specialist to assist with your orthodontic treatment. We may also correspond and forward radiographs (x-rays) when required, with your dentist and/or other specialists. During your treatment we may need to refer you to other specialists. If required we would refer you to a specialist of your choice. To ensure compliance with Federal and State Privacy Legislation we require your signed consent to work with other health care professionals, including:

Dentist: _____

Other Specialist: _____

_____	_____	_____
Date	Signature of Patient (if >18 years) or Parent /Guardian	Print Name