ORTHODONTIC PRACTICE
MEDICAL/DENTAL HISTORY FORM

Patient information

Family Name ____________________________________ Date of Birth _____/_____/____

First Name ____________________________ Preferred Name _______________________

Home Address ____

Suburb ____ Post Code ________________

Ph (h) _______________________(w)__________________(m)___________________________

Email Address---

Patient's School/Work ____

Family Dentist ______________________________ Letter of Referral YES / NO
X-Rays YES / NO

Account details (this is the person responsible for paying the account)

Name Mr Mrs Miss Ms ____

Address ____

Suburb ____ Post code ________________

Health Fund ____

Medical History

Has the patient ever suffered from any of the following conditions? (Please tick)

	Yes	No
Heart disorder/disease		
High/low blood pressure		
Rheumatic fever		
Prolonged bleeding due to injury or extractions		
Asthma		
Hepatitis		
Diabetes		
Epilepsy		
Contact with HIV/AIDS virus		
Major illness or disabilities		
Do you require antibiotic cover for dental treatment		
Speech or hearing difficulties		
Allergies		

Please list any drugs or medicine that you are allergic to:------------------------------

We respect your privacy

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers the basic details such as your name, address and telephone number but it also necessary for the orthodontist to obtain from you details regarding your general health and past medical history or surgical events. Without this general health picture, the treating orthodontist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as ‘sensitive’ and not the sort of information that you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating practitioner in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment, without your express consent
- You may seek access to the information held about you. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times
- There will be no charge made for requesting this information but there may be fees levied to cover the costs associated with the processing of the request of the copying of information
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date
- We will take reasonable steps to protect this information from misuse or loss and from unauthorized access, modification or disclosure
- Our staff are trained to respect these principles at all times

If you have any questions regarding the information we collect from you and hold in your records, please do not hesitate to ask us. We are acting in your interests at all times

I certify that the above information is correct and I have read and accepted the privacy policy. I will advise the orthodontist of any changes to the above information.

Signed ____date _______________

(Parent or guardian if under 18 years)