PATIENT DETAILS AND HISTORY FORM

peninsula ORTHODONTICS

PATIENT CONTACT DETAILS

Patient Title	Given name/s		Surname
Preferred name	Date of Birth / /	Age	Gender (circle) M / F/ Other
Patient Address	Suburb		Postcode
Telephone H	M		W

May we use SMS to communicate with you regarding appointments? Y/N

Name of School/University	Occupation

How did you find out about us? (Tick) or please specify:

☐ Facebook	☐ Instagram	☐ Google	☐ Word of mouth
☐ Dentist	☐ Family/Relative	☐ School Dental	☐ Website

DENTAL AND MEDICAL HISTORY

Regular Dentist's Name	Clinic Name	
Suburb	State	Telephone
Regular Doctor's Name	Clinic Name	
Suburb	State	Telephone

Have you visited your dentist in the last 12 months? Y/N Please provide date of last visit:	Have you undergone orthodontic treatment in the past, if so where? Y/N
Are you coming here for a second opinion? Y/N	Are you currently in orthodontic treatment? Y/N

Have we treated any other members of your family at Peninsula Orthodontics? Y/N
Name/s and relationship to patient:

Do you have any brothers or sisters?	Y/N	If so, how many?	
Are you a twin?	Y/N	Brothers:	Sisters:

Have your teeth or jaws ever been damaged in an accident? Y/N
Please explain:

Do you ever suffer from pain, clicking, limitation of movement or locking of your jaw joints? Y/N
Please explain:

Extra or missing teeth?	Y/N	Teeth grinding?	Y/N
Mouth breathing?	Y/N	Thumb/Finger sucking: (Circle)	Current – Past

What is your main concern about your teeth/bite?

Have you ever had a serious medical or surgical problem? Y/N
Please explain:

Are you currently on any medications? Y/N
Please list:

Do you have any allergies to any medications, foods, latex/rubber or other? Y/N
Please list:

Have you taken antibiotics for a period longer than 3 months? Y/N	(Females Only) Are you pregnant? Y/N

Have you or do you suffer from any of the following?

Heart Disease	Y/N	High/Low Blood Pressure	Y/N	Stroke	Y/N
Asthma	Y/N	Diabetes	Y/N	Fits/Epilepsy	Y/N
Hepatitis	Y/N	Endocrine Problems	Y/N	Cold Sores/Herpes	Y/N
Adenoid Removal	Y/N	Excessive Bleeding	Y/N	Bone Disorder	Y/N

Do you have or are you at a high risk of contracting HIV or Hepatitis B? Y/N

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BILLING INFORMATION

Please note where possible, it is practice policy to have two people listed as responsible billing parties for any fees associated with treatment.

Person/s responsible for account	Relationship to the patient	Marital Status
Title	Given Name/s	Surname
Address	Suburb	Postcode
Telephone H	M	W

Email address:

Financial statements, receipts and in house publications will be sent to this email address

Private Health Insurance Y/N	Health Fund Name
Are you covered for Orthodontics? Y/N	Have you enquired about the amount of cover? Y/N

If splitting the account, name second Person/s responsible for account.

Person/s responsible for account	Relationship to the patient	Marital Status
Title	Given Name/s	Surname
Address	Suburb	Postcode
Telephone H	M	W

Email address:

Financial statements, receipts and in house publications will be sent to this email address

HEALTH INFORMATION-PRIVACY CONSENT FORM

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health and how this information is used at this practice and to whom the information may be disclosed.

The policy of this practice is to follow these procedures:

1. The information you provide us will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.
2. We may disclose your health information (communications, images, x-rays) to other health care professionals, or require it from them if, in our judgment, it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised where possible. This would occur via mail or email between the health care professionals.
3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.
4. Your medical history, treatment records, x-rays and other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the orthodontist. Statutory fees will apply in relation to the type of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Please sign this form as confirmation that you have read and understand our privacy policy, and consent to the use of your health information as outlined above.

Patient/Parent/Guardian name:_____**Signed:**_____**Date:**_____

Patient name:_____

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 consent to work with other health care professionals.

Patient/Parent/Guardian name:_____**Date:**_____