Welcome to Oliver Orthodontics

Please take your time to answer the following questions. It will assist us greatly in providing you with the best possible orthodontic treatment.

All information will be kept confidential.

PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DETAILS

Name: ____ **Gender:** ______

Date of Birth: _____ / _____ / ______________ **Age:** ______

Home Address: ____

Home Phone: _________________________________ **Work Phone:** _______________________________

Mobile: ______________________________ **Email:** ____

Patient's School or Occupation? ____

Other family members in our practice? ____

Patient's Dentist and Address: ____

Patient's Doctor: ____

Does the patient have Dental Insurance for Orthodontics? YES / NO

If so, which fund? ______________________________________

Who can we thank for referring you? Circle where applicable.

Dentist Yellow Pages Advertisement Internet (Google, our website, etc)

Family/friend ___________________________

Other _________________________________

PARENT DETAILS (if patient is not responsible for fees)

Father: **Name:** ____

Address: ____

Home Phone: ____________________ **Work Phone:** _______________________________

Mobile: ________________________ **Email:** _____________________________________

Mother: **Name:** ____

Address: ____

Home Phone: ____________________ **Work Phone:** _______________________________

Mobile: ________________________ **Email:** _____________________________________

PARTY RESPONSIBLE FOR FEES: Father / Mother / Self / Other - _______________________________

PATIENT DENTAL HISTORY

History of trauma to teeth, mouth or face:

____

Past or present habits (eg. thumb/finger sucking, tongue thrusting, lip biting, etc):

____

Past orthodontic consultation:

____

Past orthodontic treatment (eg. plates/braces):

____

Other significant dental history (eg. missing teeth, root canal, TMJ):

____

Main concerns about patient's teeth:

____

PATIENT MEDICAL HISTORY

	Past	**Present**	**Never**	*Details*
Heart murmur				
Heart disease/condition				
Blood or bleeding disease				
Vascular disorder				
Asthma/lung condition				
Diabetes				
Epilepsy				
Eating disorder				
Nervous condition				
Growth issues				
Thyroid disease				
Hepatitis				
Headaches/migraines				
Kidney/liver disease				
HIV/AIDS				
High/low blood pressure				
Steroid therapy				
Rheumatic fever				

Have you ever taken medication for a bone disorder? YES / NO

Details of any other health conditions not mentioned above:

____

Please list ALL known allergies:

____

Are you currently taking any medications?

____

Are you pregnant/do you plan on becoming pregnant during the course of treatment? YES / NO

If you wish to discuss any medical aspects in private, please advise us.

PRIVACY POLICY

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 also use parts of your health information for research purposes in study groups or at seminars and lectures, as this may provide benefits to other patients. Your personal identity will not be disclosed.
- If any of the information we have about you is inaccurate at any point in your treatment, 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 below as confirmation that you understand and consent to our privacy policy.

Parent/Guardian 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 us with your orthodontic treatment planning. We also correspond and forward x-rays when required, with your dentist or other specialists for treatment planning. 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.

Parent/Guardian Signature: ________________________________

Name: ____ Date: _________________

Thank you for taking the time to answer these questions. We look forward to meeting you!

Sincerely,

The Oliver Orthodontics Team
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