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# Patient information and Consent Form

**Patient details** Title: (circle) Mr, Mstr, Mrs, Ms, Miss, Dr, other please specify:

Surname:……Given names:……

Address:……

Town:……Postcode:……

Phone: (Home)……(Work)……(Mobile)……

Date of Birth:……Email:……

Family Dentist:……Referred by:……

School:……Year:……

Name of Dental Health Fund (if applicable):……

**Parent details** (if patient is under 18):

Father: (Mr, Dr.)

Surname:……

Given names:……

Address:……

……

……Postcode……

Phone: (Home)……

(Work)……

(Mobile)……

Email……

Mother: (Mrs, Ms, Miss, Dr.)

Surname:……

Given names:……

Address:……

……

……Postcode……

Phone: (Home)……

(Work)……

(Mobile)……

Email……

**In case of emergency**, please contact:……

……

**Address for accounts if a person other than parent**, please supply details:

Relationship to patient: (e.g. Guardian, Aunt, Uncle, etc.)……

Title: (circle) Mr, Mrs, Ms, Miss, Dr, other please specify:

Surname:……First name:……

Address:……

Town:……Postcode:……

Phone: (Home)……(Work)……(Mobile)……

Email:……

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# Medical history

What is the main reason for seeking this consultation? ..... .....

..... .....

Has the patient had any orthodontic treatment in the past? Yes/No

If yes, what treatment?..... .....

Who carried out this treatment?..... .....

Have any other members of your family attended this practice for treatment? Yes/No

If yes, who? (eg. Brother Tom) ..... .....

Has the patient had or currently have any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Rheumatic fever | ☐ | ☐ | High blood pressure | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Heart condition | ☐ | ☐ |
| Asthma | ☐ | ☐ | Bleeding disorder | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Immune disorders | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Speech problems | ☐ | ☐ |
| Radiation Treatment | ☐ | ☐ | Accident involving teeth or jaws | ☐ | ☐ |
| Pregnant | ☐ | ☐ | Current smoker | ☐ | ☐ |
| AIDS/HIV | ☐ | ☐ | | | |

Please specify any of the following if they apply:

Past & present illnesses & conditions:.....

Past & present communicable disease status:.....

Any drug allergies:.....

Any other allergies:.....

Any other medical conditions:.....

Present medications:.....

Medical Doctor's name & phone number:.....

Signature of patient (or parent/guardian if under 18 years of age)..... .....

Date:.....

**PLEASE NOTIFY YOUR ORTHODONTIST IF AT ANY TIME THERE IS A CHANGE TO YOUR GENERAL HEALTH**

Allan J Ward
(02) 6041 3433

Award Orthodontics
607 Kiewa Street, ALBURY NSW 2640