Ocean Orthodontics

Acquaintance Form

It is important to know details about your medical history as these could affect the success of oral health care (dental treatment). The information you provide is confidential and will be handled in accordance with our privacy policy which is provided to you with this form.

For the Patient

☐Mr ☐Ms ☐Mrs

Last Name: _____ First Name: _____

Date of Birth: _____ / _____/_____ ☐Female ☐Male

Home Address: _____

Phone: _____ Work: _____ Mobile: _____ Email: _____

School (if applicable): _____Grade: _____ Dentist: _____

Family Physician: _____ Patient Referred By: _____

For the Parent/Guardian

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Contact Ph Home: _____ Contact Ph Work: _____

Person responsible for payment of Account:

Name: _____ Ph: _____ Are you in a Private Health Fund: Yes☐ No☐

Address: _____

PATIENT MEDICAL/DENTAL HISTORY

☐ I have confidential medical information that I do not wish to write down. I would prefer to speak to the orthodontist about this (please tick box)

Are you being treated by a doctor at present? Yes ☐ No ☐ Details: _____

Are you taking any tablets or medicines (prescribed or over-the-counter) at present? Yes ☐ No ☐ If YES please list medications:

_____

Have you had any abnormal reactions to local or general anaesthesia? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

Are you pregnant? (Females only) Yes ☐ No ☐

Please list any drugs or medicines you are allergic to: _____

Please list any other known allergies (including latex): _____

PLEASE TICK ONLY IF THE PATIENT HAS, OR HAS EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS.

- ☐ Steroid therapy
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart valve disorder
- ☐ Stroke
- ☐ Radiation therapy
- ☐ Cancer (benign or malignant)
- ☐ Kidney disease
- ☐ Excessive bleeding
- ☐ Heart complaint
- ☐ Nervous condition
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Heart murmur
- ☐ Cardiac pacemaker
- ☐ Prosthetic implant eg: artificial hip
- ☐ High/Low blood pressure
- ☐ Stomach or digestive condition
- ☐ Hepatitis or other liver disease
- ☐ Contact with HIV/AIDS virus
- ☐ Bronchitis, emphysema/other lung diseases
- ☐ Anaemia, leukaemia/other blood diseases
- ☐ Transplanted organ or marrow

Any other conditions(s) please list: _____

Has the patient had an orthodontic consultation previously? Yes ☐ No ☐

Has the patient had any previous orthodontic treatment? Yes ☐ No ☐

Has the patient had any injury to the teeth (this includes baby & permanent teeth)? Yes ☐ No ☐

If so, please give details _____

Has the patient had an injury to the face, jaws or chin? Yes ☐ No ☐

Has the patient had any cysts or tumours of the jaws or gums? Yes ☐ No ☐

Does the patient suck fingers or thumb or have a similar habit? Yes ☐ No ☐

Date of last dental examination _____

Reason for seeking orthodontic treatment _____

I have completed this form and have read and accept the privacy policy provided to me with this form:

Signature: _____ Date: _____